

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT. M

12089

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12085

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY Allegany		a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 41 years				
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 16 Queen City Pavement, Cumberland				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 16 Queen City Pavement, Cumberland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Harold		First Harold	Middle 			
4. DATE OF DEATH Ashworth		Month September	Year 1966			
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>			
8. DATE OF BIRTH March 27, 1901		9. AGE (In years last birthday) 65 yrs.				
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Celanese Employee		11. BIRTHPLACE (State or foreign country) Bolton, Lancashire, England				
12. CITIZEN OF WHAT COUNTRY? England						
13. FATHER'S NAME Thomas Ashworth		14. MOTHER'S MAIDEN NAME Pamela Cooper				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-07-1536				
17. INFORMANT Mrs. Betty Fey		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Sclerosis DUE TO (c)				
		INTERVAL BETWEEN ONSET AND DEATH Hours ---				
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Cumberland	(County) Allegany	(State) Maryland
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		22. DATE SIGNED Sept. 2, 1966				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-4-66	23c. NAME OF CEMETERY OR CREMATORIAL Zion Memorial Park	23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Maryland		
24. FUNERAL DIRECTOR Dale L. Merritt		ADDRESS 404 Decatur St. Cumb., Md.	25a. REC'D BY REGISTRAR DATE SEP 6 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12086

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CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS 24 WEBER ST.	
3. NAME OF DECEASED (Type or print) ROBERT		First F.	Middle ASKEY
3. SEX MALE		4. DATE OF DEATH 9. AGE (In years last birthday) SEPTEMBER 13 1966	Month 10. IF UNDER 1 YEAR Months Doy Hours Min.
6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	11. BIRTHPLACE (County & State, or foreign country) W.V.A.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Hennaway Co</i>	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME HARRY ASKEY (D)		14. MOTHER'S MAIDEN NAME ABBIE (D) Hishie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address PT'S CHART
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Reanal shutdown due to shock		INTERVAL BETWEEN ONSET AND DEATH 3 days	
(b) DUE TO Myocardial infarction, posticus,		3 days	
(c) DUE TO Acute coronary thromboses - arterioclerotic heart disease		3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 910
		20f. (City or town) 9/13	(County) 1966
		(State) 9/13/66	
21. I certify that (I) (this hospital) attended the deceased from 9/10 , 1966, to 9/13 , 1966, that (I) (we) last saw the deceased alive on 9/13 , 1966, and that death occurred at 54 M, from causes and on the date stated above.		22b. DATE SIGNED 9/13/66	
22a. SIGNATURE <i>Steinman</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. ADDRESS 59 GREENE ST. CUMBERLAND, MARYLAND.
22c. PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN, M.D.		23d. LOCATION (City or Town) (County) (State) Cumberland MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/16/66	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Zion Meme. Cem
24. FUNERAL DIRECTOR Louis Stein Inc. Cumb. MD.		25a. REC'D BY REGISTRAR DATE SEP 16 1966	25b. REGISTRAR'S SIGNATURE <i>Charles J. Geiger</i>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12087

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Oldtown c. LENGTH OF STAY IN 1b Years		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Oldtown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 1		d. STREET ADDRESS Route 1	
3. NAME OF DECEASED (Type or print) Hazel Elizabeth Athey		4. DATE OF DEATH September 10	Month 19 Day 66
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept 25, 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME Henry Snyder		11. BIRTHPLACE (County & State, or foreign country) Allegany Co., Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-34-1966	
17. INFORMANT Mrs. Francis Hess, Route 1, Oldtown, Md		14. MOTHER'S MAIDEN NAME Mrs. Emma Kirtley	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1538</i> Carcinoma, metastatic secondary to liver carcinoma		INTERVAL BETWEEN ONSET AND DEATH 6 months	
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>to liver carcinoma</i> (c) <i>2 yrs.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 at work <input type="checkbox"/> at work <input type="checkbox"/>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cumberland (County) Maryland (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 21, 1966 to Sept 10, 1966 , that (I) (we) last saw the deceased alive on 8-8 1966 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE <i>Carlton Brinsford</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) CARLTON BRINSFIELD MD		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 401 Decatur St
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 13, 1966	
23c. NAME OF CEMETERY OR CREMATORIUM St. Luke's Lutheran Cemetery		23d. LOCATION (City, town or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR John J. Hafer		ADDRESS 230 Balto Ave., Cumberland, Md	25a. REC'D BY REGISTRAR SEP 14 1966 25b. REGISTRAR'S SIGNATURE Charles Judge

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician.
director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2
should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

12092		CERTIFICATE OF DEATH				12088			
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE W. VA. b. COUNTY HAMPSHIRE					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 23HRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SPRINGFIELD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS Rural					
3. NAME OF DECEASED (Type or print) MR. CHARLES L. BAZZLE		4. DATE OF DEATH Month SEPT. Day 24 Year 1966							
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/1/94			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (County & State, or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME MICHAEL BAZZLE				14. MOTHER'S MAIDEN NAME AMANDA BAKER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation DUE TO 260 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Diabetic Acidosis DUE TO last. (c) Diabetes Mellitus								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 9123		20f. (City or town) 9123 (County) 9124 (State) 9125			
21. I certify that (I) (this hospital) attended the deceased from 9/23/66 to 9/24/66 , that (I) (we) last saw the deceased alive on 9/23/66 , and that death occurred at 1:00 P.M. from causes and on the date stated above.									
22a. SIGNATURE L. L. Ley		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22b. DATE SIGNED 9/26/66	
22c. PHYSICIAN'S NAME (Type) DR. LEO LEY		22d. ADDRESS 456 N. CENTRE ST. CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-27-66		23c. NAME OF CEMETERY OR CREMATORIAL Springfield Hill		23d. LOCATION (City or Town) Springfield (County) Hampshire (State) W. Va.			
24. FUNERAL DIRECTOR S. Shaffer		ADDRESS Romney, W. Va.		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE SEP 30 1966			

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1964-1965 TURNER

1965-1966 TURNER

1966-1967 TURNER

1967-1968 TURNER

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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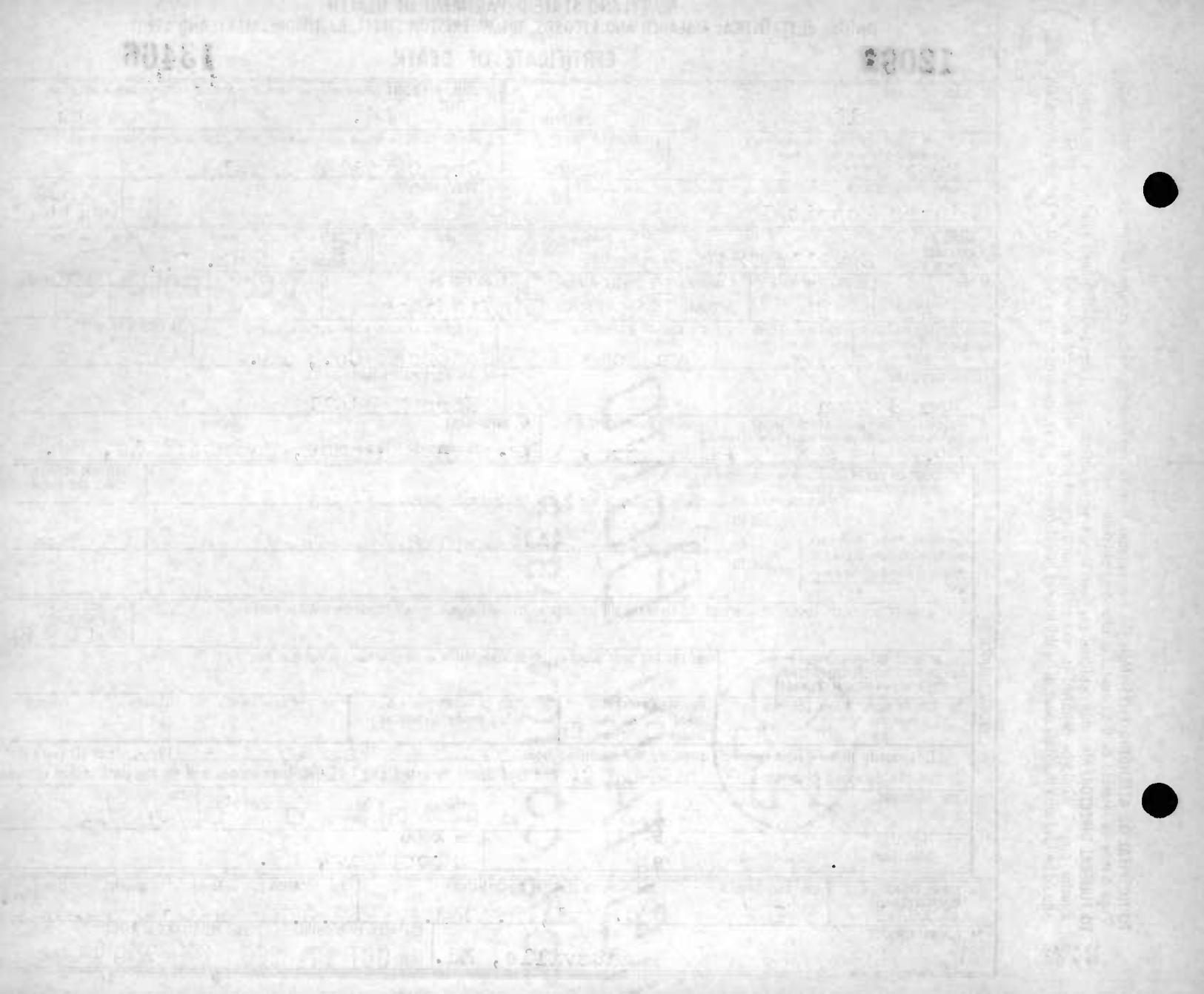
CERTIFICATE OF DEATH

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Garrett ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN lb 4 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Savilla Edith Beeman		First	Middle
S. SEX F	6. COLOR OR RACE W	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED
8. DATE OF BIRTH 4/10/1910		9. AGE (In years lost birthday) 56 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Somerset Co., Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Dan Stevanus		14. MOTHER'S MAIDEN NAME Nora Kendall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Mr. Henry Beeman, Grantsville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized carcinomatosis</i>		INTERVAL BETWEEN ONSET AND DEATH 18 mos.	
DUE TO 1750 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Primary ovarian carcinoma</i>		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-22-1966, to 9-26-1966, that (I) (we) last saw the deceased alive on 9-25-1966, and that death occurred at 4:35AM, from causes and on the date stated above.		22b. DATE SIGNED 10/13/66	
22a. SIGNATURE <i>G. Paige Strong</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS Frostburg, Md.
22c. PHYSICIAN'S NAME (Type) A. Paige Strong		23d. LOCATION (City or Town) (County) (State) R. D. Meyersdale Somerset Pa.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/29/66	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS St. Paul, Pa. Cem.
24. FUNERAL DIRECTOR <i>Don Newman</i>		25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE DATE OCT 17 1966



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

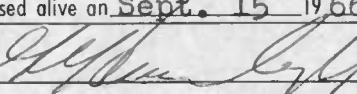
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CERTIFICATE OF DEATH

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Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 52 yrs.							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED First Joseph M. Breighner		4. DATE OF DEATH Sept. 20, 1966							
5. SEX Male White		6. COLOR OR RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 7, 1913		9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (County & State, or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Roy M. Breighner		14. MOTHER'S MAIDEN NAME Bertha Dove		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) yes War II		16. SOCIAL SECURITY NO. 214-05-8613		17. INFORMANT Mrs. Eleanor Breighner Address Cumberland, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Acute coronary occlusion DUE TO								INTERVAL BETWEEN ONSET AND DEATH minutes	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease. DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus.								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from May 16, 1952, to June 23, 1966 that (I) (we) last saw the deceased alive on Sept. 15, 1966, and that death occurred at 3PM M, from causes and on the date stated above.									
22o. SIGNATURE 		22b. DATE SIGNED Sept. 20, 1966							
22c. PHYSICIAN'S NAME (Type) Dr. G. Overton Himmelwright		22d. ADDRESS 133 Virginia Ave., Cumberland, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 23, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Davis Memorial Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany			
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
				DATE SEP 26 1966		Charles Judge			

22032

1973-1-10-340165

22032

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12095 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 120911

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any part is necessary, please execute, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS 111 N. Walnut Place	
3. NAME OF DECEASED (Type or print) Lily Mae Brown		4. DATE OF DEATH Month Day Year September 29 1966	
5. SEX Female		6. COLOR OR RACE Black	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Sept 27, 1886	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania	
10c. BIRTHPLACE (State or foreign country) U.S.A.		11. MOTHER'S MAIDEN NAME Elizabeth Wallace	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Meigs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-10-2598D	
17. INFORMANT James L. Brown, 111 N. Walnut Place, Cumberland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Corona ry Occlusion	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Coronary Sclerosis		INTERVAL BETWEEN ONSET AND DEATH 30 Minutes	
DUE TO (b) (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE Benedict Skitarelic		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED September 29, 1966	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF October 3, 1966	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Woodlawn Cemetery		22d. LOCATION (City, town, or country) Cumberland, Maryland	
23. FUNERAL DIRECTOR John J. Hafer		24a. REC'D BY REGISTRAR Charles Judge	
VS. A15ME SM 9/60		24b. REGISTRAR'S SIGNATURE OCT 5 1966	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Use pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12086

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12091

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Tennessee	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		b. COUNTY Hawkins	
c. LENGTH OF STAY IN 1b 3 Hrs. 35 Min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Surgoinsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS Rt. #1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) James Sherrell Burke		First	Middle
4. DATE OF DEATH Sept. 10, 1966		Month	Year
5. SEX Male		5. COLOR OR RACE White	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
7. DATE OF BIRTH May 10, 1945		8. AGE (In years last birthday) 21 yrs.	9. IF UNDER 1 YEAR Months Days
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		11. BIRTHPLACE (State or foreign country) Tennessee	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Lee Burke		14. MOTHER'S MAIDEN NAME Virginia Haygood	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes At Present		16. SOCIAL SECURITY NO. 413-68-1760	17. INFORMANT Address Hugh E. Housewright, Jr. Surgoinsville Tenn.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8164 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH About 4 Hours	
DUE TO (b) DUE TO (c)		Intracranial Hemorrhage Skull Fracture; Transection of second cervical vertebrae	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile collision	
20c. TIME OF INJURY Month, Day, Year Hour 6:00 AM Sept. 10 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route # 28, Near Wiley Ford, Mineral, WV
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED September 10, 1966	
ACTUAL SIGNATURE Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 16, 1966	23c. NAME OF CEMETERY OR CREMATORIUM Methodist Cemetery
24. FUNERAL DIRECTOR Philip B. Wendt 121 Memorial Ave. Cumb. Md.		23d. LOCATION (City or Town) ADDRESS Surgoinsville, Tenn.	(County) (State)
25a. REC'D BY REGISTRAR DATE SEP 14 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12097

CERTIFICATE OF DEATH

121192

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE PENNSYLVANIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		b. COUNTY BEDFORD	
c. LENGTH OF STAY IN 1b 48 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYNDMAN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle M.	Last BURKETT
4. DATE OF DEATH	Month SEPTEMBER	Day 22	Year 1966
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-31-87
9. AGE (In years last birthday) 79 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OTORAIL ROAD Employee	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Bedford Co. Penna
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME LEVIAH BURKETT	14. MOTHER'S MAIDEN NAME CATHERINE LOWERY		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	16. SOCIAL SECURITY NO. 705-09-5917	17. INFORMANT	Address MEMORIAL HOSPITAL, CUMBERLAND, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) multiple metastases			INTERVAL BETWEEN ONSET AND DEATH
17 7X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cervical carcinoma of prostate			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 8-8-66 , 19 1966 , 1:45 A.M. 9-2-2 , thot (I) (we) lost saw the deceased alive on 1-2-1966 and that death occurred at M , from causes and on the date stated above.			
22d. SIGNATURE DR. J. VALDES		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. J. VALDES		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF Sept. 25, 1966	23c. NAME OF CEMETERY OR CREMATORIAL PALO ALTO Cemetery	23d. LOCATION (City or Town) (County) (State) HYNDMAN, Bedford Co. PA
24. FUNERAL DIRECTOR Harvey N. Zeegler, Hyndman, PA	ADDRESS	25a. REC'D BY REGISTRAR DATE SEP 29 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

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FOR STAN
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12098

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12098

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and item 7 event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN lb 65 years		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			d. STREET ADDRESS 38 VIRGINIA AVENUE		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First JOHN	Middle M.	Lost	4. DATE OF DEATH Month SEPTEMBER Day 15 Year 1966
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	8. DATE OF BIRTH 9-11-82	9. AGE (In years L. bday) 84 yrs.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) MARTINSBURG, W.VA.	
13. FATHER'S NAME Charles E. Cage			14. MOTHER'S MAIDEN NAME Leah F. Staubs		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. Peace Time		17. INFORMANT PT'S CHART	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9040 DUE TO Subdural Hemorrhage INTERVAL BETWEEN ONSET AND DEATH 4 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Contusions of Brain 4 days (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell at Home			
20c. TIME OF INJURY Month, Day, Year Hour o.m. Sept. 11 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Home	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED September 15, 1966			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		Address (Street, city, town, or county) Cumberland, Alleg. Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF Sept. 18, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany		
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.	ADDRESS	25a. REC'D BY REGISTRAR DATE SEP 19 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

12099

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12094

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. # 6 Cumberland,		d. STREET ADDRESS Rawlings,		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D. O. A. Sacred Heart Hosp.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Vance		First	Middle	Lost	4. DATE OF DEATH Sept. 17	Month	Year 1966	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	B. DATE OF BIRTH Jan. 25, 1925		9. AGE (In years last birthday) 41 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		10b. KIND OF BUSINESS OR INDUSTRY Bakery		11. BIRTHPLACE (State or foreign country) McCoole, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Henry Chucci				14. MOTHER'S MAIDEN NAME Lula Leatherman				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes, W. W. # 2		16. SOCIAL SECURITY NO. 721-16-9533		17. INFORMANT Mrs. Betty L. Chucci Rt. # 6 Cumb. Md.		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b) DUE TO (c)		CORONARY OCCLUSION CORONARY SCLEROSIS WITH THROMBOSIS		INTERVAL BETWEEN ONSET AND DEATH SUDDEN		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED September 17, 1966		
ACTUAL SIGNATURE EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Cumberland, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/20/66		23c. NAME OF CEMETERY OR CREMATORIAL Abe Cemetery		23d. LOCATION (City or Town) (County) (State) Mr. Ridgeley, Mineral W. Va.		
24. FUNERAL DIRECTOR H. Wayne George		ADDRESS Cumberland, Maryland		25a. REC'D BY REGISTRAR DATE SEP 22 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12100

CERTIFICATE OF DEATH

12195

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE W. VA.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 1 DAY		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) EMMETT L. COX			First	Middle	Last
4. DATE OF DEATH SEPTEMBER 9, 1966			Month	Day	Year
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	8. DATE OF BIRTH 9-8-1966
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (County & State, or foreign country) Cumberland, MD.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME COX, LEONARD LEE			14. MOTHER'S MAIDEN NAME HAZEL A. KESNER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO.		
17. INFORMANT MEMORIAL HOSPITAL-CUMBERLAND, MD.			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Preneumonia 24 wks					
776 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) (c)					
DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 6:05 A.M. from causes and on the date stated above.					
22a. SIGNATURE Julian S. Whitworth, M.D.					
22b. DATE SIGNED 9/12/1966					
22c. PHYSICIAN'S NAME (Type) DR. F. B. WHITWORTH		22d. ADDRESS 305 WASHINGTON ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 10, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Ft Ashby Cemetery	23d. LOCATION (City or Town) Ft Ashby, W. Va.	(County) (State)
24. FUNERAL DIRECTOR Allen M. Rotnick, Keyser W. Va.			ADDRESS	25a. REC'D. BY REGISTRAR SEP 15 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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12102

CERTIFICATE OF DEATH

121096

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 25 Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 411 Furnace Street		d. STREET ADDRESS 411 Furnace Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Jerome Patrick Creegan		First Jerome	Middle Patrick
4. DATE OF DEATH September 22 1966	Month September	Day 22	Year 1966
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH April 19, 1905
9. AGE (In years last birthday) 61 yrs.	10. KIND OF BUSINESS OR INDUSTRY Retired Employee-Queen City Brewing Co.	11. BIRTHPLACE (County & State, or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Edward Creegan	14. MOTHER'S MAIDEN NAME Lucy Simpson	Address 411 Furnace St	Cumberland, Md
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	16. SOCIAL SECURITY NO. 211-05-9867	17. INFORMANT Mrs. Germaine Creegan	INTERVAL BETWEEN ONSET AND DEATH
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c)	Momenta		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov. 61 to Sept. 22 1966 that (I) (we) lost saw the deceased alive on Aug. 4 1966 and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE <i>Wayne C. Spiggle</i>		9:30 am Sept. 22 1966 M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 9/23/66
22c. PHYSICIAN'S NAME (Type) Wayne C. Spiggle M.D.		22d. ADDRESS 126 N. Smallwood Street, Cumb.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/24/66	23c. NAME OF CEMETERY OR CREMATORIAL S.S. Peter & Paul Cemetery
24. FUNERAL DIRECTOR Ruth E. Silcox		ADDRESS Cumberland Maryland 21502	25a. REC'D BY REGISTRAR DATE SEP 27 1966
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12101

CERTIFICATE OF DEATH

12097

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		b. COUNTY ALLEGANY		
c. LENGTH OF STAY IN lb 2 Weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS RT#1, BOX 464		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) ELLEN		First ELLEN	Middle NORA	
4. DATE OF DEATH SEPT. 16 1966		Lost CREEK	Month Sept.	
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED	
8. DATE OF BIRTH JUNE 5, 1986		9. AGE (In years last birthday) 80 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE At Home		10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (County & State, or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME HENRY LEE(DECEASED)		14. MOTHER'S MAIDEN NAME CHARLOTTE RICE (DECEASED)		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-10-7764-1		
17. INFORMANT PATIENTS CHART		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR HEMORRHAGE		INTERVAL BETWEEN ONSET AND DEATH		
33IX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) ESSENTIAL HYPERTENSION				
DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-2 1966 , to 9-16 1966 , that (I) (we) last saw the deceased alive on 9-15 1966 , and that death occurred at 4P M , from causes and on the date stated above.				
22a. SIGNATURE <i>Long Glick</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 9-17-66	
22c. PHYSICIAN'S NAME (Type) DR. M. GLICK AND DR. W. SPIGGLE		22d. ADDRESS N. SMALLWOOD ST., CUMBERLAND, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/18/66	23c. NAME OF CEMETERY OR CREMATORIAL Centerville Fshp Cemetery	23d. LOCATION (City or Town) (County) (State) Centerville Bedford Penna
24. FUNERAL DIRECTOR H. Lee Silcox		ADDRESS Cumberland Maryland 21502	25a. RECD BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE SEP 19 1966

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12103

CERTIFICATE OF DEATH

12198

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		d. STREET ADDRESS 315 Emily Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Stanley		First E.	Middle Davies
4. DATE OF DEATH 9	Month 13	Doy 1966	Year
5. SEX M	6. COLOR OR RACE W	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 11/15/05		9. AGE (In years last birthday) 60 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carmen Helper		10b. KIND OF BUSINESS OR INDUSTRY B & O RR	
11. BIRTHPLACE (County & State, or foreign country) Cumberland Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Davies (deceased)		14. MOTHER'S MAIDEN NAME Alice (deceased) Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-05-9373	
17. INFORMANT patient's chart		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 5810 DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) ischemia - DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 43 Greene St., Cumberland, Md.
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from January 13, 1966 to July 13, 1966 that (I) (we) last saw the deceased alive on July 13, 1966 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE B. Schindler		22b. DATE SIGNED 10-16-66	
22c. PHYSICIAN'S NAME (Type) Dr. B. Schindler		22d. ADDRESS 43 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 16, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park
23d. LOCATION (City or Town) Cumberland, Md.		(County) (State) Allegany	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS	25a. REC'D BY REGISTRAR DATE SEP 19 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or entombment, and in any event, within 72 hours after death.

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12104

CERTIFICATE OF DEATH

12098

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY GARRETT					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 36 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRANTSVILLE		d. STREET ADDRESS					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) JANE		First J.	Middle H.	Last DAVSS	4. DATE OF DEATH SEPTEMBER 10 1966	Month SEPTEMBER	Day 10	Year 1966			
S. SEX FEMALE	6. COLOR OR RACE WHITW	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-16-1923	9. AGE (In years last birthday) 43 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) GARRETT CO. MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME DANIEL J. HUMMEL				14. MOTHER'S MAIDEN NAME SARAH E. TURNER		Address					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. —		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkin's Sarcoma - Generalized						INTERVAL BETWEEN ONSET AND DEATH 10/1 X					
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. —		(b) —									
		DUE TO DUE TO (c) —									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) —		(County) —		(State) —	
21. I certify that (I) (this hospital) attended the deceased from June 1966 to Sept 1966 that (I) (we) last saw the deceased alive on 10 Sept 1966 , and that death occurred at 4:35 PM , from causes and on the date stated above.											
22a. SIGNATURE Julia B. Whitworth		M.D. —		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED —	
22c. PHYSICIAN'S NAME (Type) DR. F. B. WHITWORTH		22d. ADDRESS 305 WASHINGTON ST.									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/13/66		23c. NAME OF CEMETERY OR CREMATORIAL GRANTSVILLE		23d. LOCATION (City or Town) GRANTSVILLE		(County) GARRETT CO. MD.		(State) —	
24. FUNERAL DIRECTOR Don Newman, Grantsville, Md		ADDRESS —		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge					

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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12105

CERTIFICATE OF DEATH

12100

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. LENGTH OF STAY IN 1b 15 Yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) rural		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport	
f. STREET ADDRESS Rt. 1		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rose Elizabeth Diehl		4. DATE OF DEATH Month Sept. Day 3 Year 1966	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED WIDOWED <input checked="" type="checkbox"/>		8. NEVER MARRIED DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Aug. 30, 1897		10. AGE (In years lost birthday) 69 yrs.	
11. BIRTHPLACE (County & State, or foreign country) Tucker-W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James T. Shaffer		14. MOTHER'S MAIDEN NAME Susan R. Ryan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT William Diehl		Address Burlington, W. Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) Myocardial infarction		DUE TO 260 X	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) atherosclerosis		DUE TO 260 X	
stating the underlying cause (c) Diabetes mellitus		DUE TO 260 X	
INTERVAL BETWEEN ONSET AND DEATH minutes			
10 yrs.			
20 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Fracture clav.			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1966 , to 1966 , that (I) (we) last saw the deceased alive on 9-2-66 , and that death occurred at W. Va. M. from causes and on the date stated above.			
22a. SIGNATURE William W. Lesh		22b. DATE SIGNED 9-3-66	
22c. PHYSICIAN'S NAME (Type) William W. Lesh		22d. ADDRESS Westernport, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/5/66	
23c. NAME OF CEMETERY OR CREMATORIAL Queens Point		23d. LOCATION (City or Town) (County) (State) Keyser W. Va.	
24. FUNERAL DIRECTOR E. B. Boral		25a. ADDRESS Westernport, Md.	
25b. REGISTRAR'S SIGNATURE DATE SEP 3 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #5,6,7,8 & 9 Film #G381 10/7/66 pc

12106

CERTIFICATE OF DEATH

12101

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Pages 1 and 2 should be detached for use as the burial-transit permit, then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN lb 3 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grantsville (Rural) 11-2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) DORA		First H.	Middle	Lost	4. DATE OF DEATH DURST 9 - 21	Month	Doy Year 1966.
S. SEX F	6. COLOR OR RACE W	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH May 4, 1881	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. DAYS Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Avilton, Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Sadris McKenzie				14. MOTHER'S MAIDEN NAME Annie Chaney			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-52-9801		17. INFORMANT Mrs. Carrie Britt, Frostburg, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Cardio-Vascular disease</u> 5 years 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> 10 years. DUE TO (c) <u>Senility</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cellulitis st. lower leg.							
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-10, 1960, to 9-21, 1966, that (I) (we) last saw the deceased alive on 9-20 1966, and that death occurred at 750 # M, from causes and on the date stated above.							
22a. SIGNATURE H.C. Diehl				22b. DATE SIGNED 9-21-66			
22c. PHYSICIAN'S NAME (Type) H.C. Diehl, M.D.		22d. ADDRESS 39 W. Main St. FROSTBURG, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/24/66		23c. NAME OF CEMETERY OR CREMATORIAL New Germany Ref. Cem.		23d. LOCATION (City or Town) (County) (State) Grantsville, Garrett, Md.	
24. FUNERAL DIRECTOR Don Newman, Grantsville, Md.				ADDRESS		25a. REC'D BY REGISTRAR OCT 5 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

2015

2015

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12107

CERTIFICATE OF DEATH

12102

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY ALLEGANY CO.			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			b. COUNTY ALLEGANY		
c. LENGTH OF STAY IN lb			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA VALE		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			d. STREET ADDRESS 61 LA VALE COURT		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First ROSILLA MAY	Middle DYCHE	4. DATE OF DEATH	Month SEPT. Doy 2 Year 1966
S. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH 7-30-1889	9. AGE (In years last birthday) 77 yrs.	10. IF UNDER 1 YEAR Months 0 Doy 0 Hours 0 Min. 11. IF UNDER 24 HRS.
FEMALE		WHITE	<input type="checkbox"/> DIVORCED		
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) GREAT CACAPON, W. VA.	
13. FATHER'S NAME WILLIAM CRAWFORD		14. MOTHER'S MAIDEN NAME REBECCA A SIPES		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address W. H. DYCHE LA VALE, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Degeneration</i> INTERVAL BETWEEN ONSET AND DEATH 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary Artery Disease</i> DUE TO (c) <i>Atherosclerosis, generalized</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Doy, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>8/24 1966</i>	20f. (City or town) LA VALE	(County) (State) 9/2 1966
21. I certify that (I) (this hospital) attended the deceased from <i>8/24 1966</i> to <i>9/2 1966</i> , that (I) (we) last saw the deceased alive on <i>9/2 1966</i> , and that death occurred at <i>6:20 PM</i> from causes and on the date stated above.					
22a. SIGNATURE <i>Leo H. Ley Jr.</i>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22b. DATE SIGNED <i>9/3/66</i>		
22c. PHYSICIAN'S NAME (Type) DR. LEO H LEY		22d. ADDRESS 456 N CENTRE ST. CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF SEPT. 5, 1966	23c. NAME OF CEMETERY OR CREMATORIAL HILLCREST BURIAL PARK	23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD.	
24. FUNERAL DIRECTOR BYRON KIGHT		ADDRESS CUMBERLAND, MD.	25a. REC'D BY REGISTRAR SEP 13 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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1882

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12108

CERTIFICATE OF DEATH

12108

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 11. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 25 years		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First MARY	Middle VERONICA	4. DATE OF DEATH Month 9-9 Year 1966	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-22-93	
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Dept. Store		
13. FATHER'S NAME John Joseph Fahey		14. MOTHER'S MAIDEN NAME Margaret Ellen Carney		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		
17. INFORMANT		Address		
PT'S CHART				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Disease 1530 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma Cecum (c)				INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6/5/66 to 9/9/66 , that (I) (we) last saw the deceased alive on 6/5/66 , and that death occurred at Cumberland M., from causes and on the date stated above.				22b. DATE SIGNED 9/9/66
22a. SIGNATURE <i>Dr. L. Ley, M.D.</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 9/9/66	
22c. PHYSICIAN'S NAME (Type) DR. L. LEY, M.D.		22d. ADDRESS 456 N. CENTRE STREET CUMBERLAND, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 12, 1966	23c. NAME OF CEMETERY OR CREMATORIAL St. Patrick's Cemetery	23d. LOCATION (City or Town) (County) (State) Cumberland Md. Allegany	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.	ADDRESS	25a. REC'D BY REGISTRAR SEP 14	25b. REGISTRAR'S SIGNATURE Charles Judge	DATE 1966

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

12109

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12104

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY Allegany		a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b				
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. # 4 Cumberland,		d. STREET ADDRESS Christie Rd.				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Francis Patrick Fairall		First Francis	Middle Patrick			
4. DATE OF DEATH Sept. 18, 1966		Last Fairall	Month Sept.			
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH Aug. 26, 1919		9. AGE (In years last birthday) 47 yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail rm. employed		10b. KIND OF BUSINESS OR INDUSTRY Newspaper				
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME John Fairall		14. MOTHER'S MAIDEN NAME Sarah Schaffer				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes, W. W. # 2		16. SOCIAL SECURITY NO. 214-07-1974				
17. INFORMANT Mrs. Lillian Fairall Rt. # 4 Cumberland, Md.		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201		INTERVAL BETWEEN ONSET AND DEATH Sudden				
DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Coronary Thrombosis						
DUE TO (c) Coronary Sclerosis						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Cumberland	(County) Allegany	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/21/66	23c. NAME OF CEMETERY OR CREMATORIAL Mount Herman Cemetery	23d. LOCATION (City or Town) Cumberland	(County) Allegany	(State) Md.
24. FUNERAL DIRECTOR H. Wayne George		ADDRESS Cumberland, Maryland	25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	
VR A15ME (5) 6M 1/66		DATE SEP 22 1966				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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12110
BETTER BUSINESS FORMS, INC., BALTIMORE, MD. 21201
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH
12105

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 11/8/1957		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Marie	Middle S.	Last Frankland	
4. DATE OF DEATH September 6, 1966	Month Year	Day	Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/17/1873	
9. AGE (In years last birthday) 93 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Backnang, Germany	
12. CITIZEN OF WHAT COUNTRY? U. S. A.	13. FATHER'S NAME Christian Stark	14. MOTHER'S MAIDEN NAME Christina Gensenjager		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT P.O. Box 599 Address Cumberland, Md. Allegany County Infirmary records.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ① Hypocardia, Ch degenerativa, Senile 443 X Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ② Bradycardia (c) ③ Arterio Sclerosis, General & Cerebral ④ Hypotension				
INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
19				
21. I certify that (I) (this hospital) attended the deceased from Jan., 1966 , to Sept. 6, 1966 , that (I) (we) last saw the deceased alive on Sept. 5, 1966 , and that death occurred at A. M., from the causes and on the date stated above.	22a. SIGNATURE <i>Lee B. Mathews, M. D.</i>	22b. DATE SIGNED 9/6/1966		
22c. PHYSICIAN'S NAME (Type) Lee B. Mathews, M. D.	22d. ADDRESS 49 Greene St., Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/8/66	23c. NAME OF CEMETERY OR CREMATORIUM Philos Cem.	23d. LOCATION (City, town or county) Westernport	(State) Md.
24. FUNERAL DIRECTOR <i>E. B. Mathews, Westernport, Md.</i>	25a. ADDRESS	25b. REGISTRAR'S SIGNATURE	25a. REC'D BY REGISTRAR SEP 13 1956	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
VR A15 (4) 20M 1/65				

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Classification

1. INTRODUCTION

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6. **प्राणी विज्ञान** (Biology)

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if different, within 72 hours after death.

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12111

CERTIFICATE OF DEATH

12106

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. LENGTH OF STAY IN 1b 73 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport 01-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 107 Cromer Street				d. STREET ADDRESS 107 Cromer Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Carrie		First Elizabeth	Middle Gales	Last September	DATE OF DEATH	Month 29	Day Year 19 66
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 1, 1893	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Henry Biddle				14. MOTHER'S MAIDEN NAME Sarah Opal			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Virginia Miller		Address Westernport, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO last. (c)							
INTERVAL BETWEEN ONSET AND DEATH 14 Hours							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 28, 1966 , to Sept 29, 1966 , that (I) (we) last saw the deceased alive on Sept 28, 1966 , and that death occurred at 3:30 A.M. , from causes and on the date stated above.							
22a. SIGNATURE Paul R. Wilson				22b. DATE SIGNED Sept. 30, 1966			
22c. PHYSICIAN'S NAME (Type) Paul R. Wilson, MD		22d. ADDRESS Piedmont, W. Va.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 1, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Philos Cemetery		23d. LOCATION (City or Town) (County) (State) Westernport Allegany, Md.	
24. FUNERAL DIRECTOR E. L. Boul - Westernport, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE OCT 3 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

12112

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12107

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Alexandria ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 1 week	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria		83-3
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital			d. STREET ADDRESS 153 Wesmond Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Female Leona		First	Middle	Last	4. DATE OF DEATH Sept. 17 1966
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED	8. NEVER MARRIED DIVORCED	9. DATE OF BIRTH Jan. 16, 1917	10. AGE (In years last birthday) 49 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Garment		11. BIRTHPLACE (State or foreign country) Cumberland, Md.	
13. FATHER'S NAME Harley Robinette			14. MOTHER'S MAIDEN NAME (Step) Ida Mae Robinette		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. George Gormer, Alexandria, Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Coronary Sclerosis with Thrombosis DUE TO — stating the underlying cause (c) —					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> September 17, 1966 Address (Street, city, town, or county) <i>Cumberland, Maryland</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 20, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park	23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.			ADDRESS	25a. REC'D BY REGISTRAR DATE SEP 22 1966	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12113

CERTIFICATE OF DEATH

12108

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 2/8/1962	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport	
3. NAME OF DECEASED First Amelia Middle Jane Last Graney (Type or print)		4. DATE OF DEATH Month September Day 18 , Year 1966	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED WIDOWED <input checked="" type="checkbox"/>		8. NEVER MARRIED DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 8/29/1878		10. AGE (In years last birthday) 88 yrs.	
11. IF UNDER 1 YEAR Months <input type="checkbox"/>		12. IF UNDER 24 HRS. Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Midland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Seymour		14. MOTHER'S MAIDEN NAME Laura Warren	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT P.O. Box 599, Address Cumberland, Md Allegany County Infirmary records.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (C) Hypertension, atherosclerosis, Senile 443X DUE TO (a) arteriosclerosis, senile, E. Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) fracture of hip (ed) DUE TO (c) fracture left ankle (ed)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/8/1962 , 19, to 9/18/66 , 19, that (I) (we) last saw the deceased alive on 9/17/66 , 19, and that death occurred at P. M. , from causes and on the date stated above.			
22a. SIGNATURE A. Mathews Jr.		22b. DATE SIGNED 9/19/1966	
22c. PHYSICIAN'S NAME (Type) Lee B. Mathews, M. D.		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-20-66	
23c. NAME OF CEMETERY OR CREMATORIAL Philos Cemetery		23d. LOCATION (City or Town) (County) (State) Westernport Alle. Md	
24. FUNERAL DIRECTOR W.H. Fredlock Jr		ADDRESS Piedmont W.Va	
25a. REC'D BY REGISTRAR DATE SEP 23 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12114

CERTIFICATE OF DEATH

12119

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. LENGTH OF STAY IN lb 58 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 340 Davidson Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Vernon	Middle Cornelius	4. DATE OF DEATH Sept 2 1966
S. SEX male	6. COLOR OR RACE white	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 31, 1897
9. AGE (In years last birthday) 69 yrs.	10. KIND OF BUSINESS OR INDUSTRY Grocery Prop.	11. BIRTHPLACE (County & State, or foreign country) Cumberland, Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William Hager	14. MOTHER'S MAIDEN NAME Edna M. Ardinger	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.	
16. SOCIAL SECURITY NO. 220-30-8768	17. INFORMANT Mrs. Anna Hager, 340 Davidson St. Cumb. Md.	Address Pt. chart	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Industrial Obstruction		INTERVAL BETWEEN ONSET AND DEATH 6 weeks	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause 1533		DUE TO (b) Generalized Abdominal Carcinomatosis 4 mos.	
		DUE TO (c) Carcinoma of Sigmoid Colon 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> or work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from to July, 1966, to Sept, 1966 that (I) (we) last saw the deceased alive on 2 July 1966 , and that death occurred at 4:15 P.M. from causes and on the date stated above.			
22a. SIGNATURE James B. Stegmaier		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 3 Sept 1966
22c. PHYSICIAN'S NAME (Type) J. G. Stegmaier, M.D.		22d. ADDRESS 122 South Centre Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/15/66	23c. NAME OF CEMETERY OR CREMATORIAL SS. Peter & Paul Cem.
23d. LOCATION (City or Town) Cumberland, Allegany		(County) (State) Md.	
24. FUNERAL DIRECTOR H. Wayne George		ADDRESS Cumberland, Maryland	
25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE SEP 8 1966			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12115

CERTIFICATE OF DEATH

12110

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 32 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 1428 DOGWOOD CT. WHITE OAKS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLIFTON		First LUTHER	Last HANLIN
4. DATE OF DEATH SEPT. 4 1966	Month	Day	Year
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 3-11-1908
9. AGE (In years last birthday) 58 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist Helper	10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (County & State, or foreign country) W. VA. -RIG	12. CITIZEN OF WHAT COUNTRY? U.S. A.
13. FATHER'S NAME WILLIAM R HANLIN	14. MOTHER'S MAIDEN NAME IDA V LAMBERT		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes	16. SOCIAL SECURITY NO. War II & Korean 220-10-7928	17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Locati Cocore, Ockesewi</i>			INTERVAL BETWEEN ONSET AND DEATH <i>4201</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Sleep Impaired upon Recent Myocardial</i>			
DUE TO (c) <i>Infection due to Hyperkalemia Arteriosclerosis Cardiopathy</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Disease</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	20f. (City or town) 83 (County) 9/4 (State) 1966
21. I certify that (I) (this hospital) attended the deceased from 83 , 19 66 , to 9/4 , 19 66 , that (I) (we) last saw the deceased alive on 9/4/66 19 66 , and that death occurred at 9:55 MPM causes and on the date stated above.		22b. DATE SIGNED 9/6/66	
22a. SIGNATURE <i>DR. OVERTON D HIMMELWRIGHT</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 133 VIRGINIA AVE. CUMBERLAND, MD.
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 7, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park	23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.	ADDRESS	25a. REC'D BY REGISTRAR SEP 18 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

12116

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12111

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE W. Va.							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b ?							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D. O.A. Memorial Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wiley Ford 85-3							
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Madlean Ianes Hannas		4. DATE OF DEATH Sept. 27 1966							
5. SEX Female White		6. COLOR OR RACE 7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 27, 1909		9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Dofs Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Green Ridge, Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Kifer		14. MOTHER'S MAIDEN NAME Estella Hutzell		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Herbert Hannas, Wiley Ford, W. Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } (b) DUE TO lost. } (c) DUE TO		Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH Sudden					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Coronary Sclerosis		-----					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Noturol causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>						22. DATE SIGNED September 27, 1966			
ACTUAL SIGNATURE Benedict Skitarelic		EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 30, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany			
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE OCT 3 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12117

CERTIFICATE OF DEATH

12118

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN lb 44 DAYS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			d. STREET ADDRESS 218 CECELIA ST.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ROBERT			First M	Middle HOPCRAFT	Last SEPT 17 1966
4. DATE OF DEATH SEPT 17 1966		Month SEPT	Day 17	Year 1966	
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	B. DATE OF BIRTH 3-27-86	9. AGE (In years last birthday) 80 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). Retired B & O Machinist			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME JACK HOPCRAFT			14. MOTHER'S MAIDEN NAME MOLLY RHODES		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 705-10-3792	17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X <i>Diffuse Cerebral Vascular Disease</i> INTERVAL BETWEEN ONSET AND DEATH 3 yrs					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumb Alleg Md	20f. (City or town) Cumb Alleg Md	(County) (State) Allegany Md
21. I certify that (I) (this hospital) attended the deceased from 9/7/66 , 19 to 9/17/66 , 19, that (I) (we) last saw the deceased alive on 9/17/66 , 19, and that death occurred at 8:40 PM , from causes and on the date stated above.					
22a. SIGNATURE R. J. Williams					
22c. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS		22d. ADDRESS 122 S CENTER ST. CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/21/66	23c. NAME OF CEMETERY OR CREMATORIAL St. Luke's Cemetery	23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland	
24. FUNERAL DIRECTOR Ruth E. Silcox			ADDRESS Cumberland Maryland 21502	25a. REC'D BY REGISTRAR SEP 20 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #3 Film #G381 10/5/66 pc

CERTIFICATE OF DEATH

12118

12118

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 2 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
3. NAME OF DECEASED (Type or print) HARVEY		First R.	Middle Landis
4. DATE OF DEATH SEPT. 16 1966		Month Sept.	Doy Year 16 1966
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	B. DATE OF BIRTH 1-23-1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN FRANK HOYLE		14. MOTHER'S MAIDEN NAME VIRGINIA MILLER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute Coronary Thrombosis</i> DUE TO <i>heart</i> 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma left lung</i> DUE TO <i>lungs</i> (c) <i>Arteriosclerosis</i> DUE TO <i>syn</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Doy, Year Hour o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) 19		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 16 , 1966 to Sept. 16 , 1966, that (I) (we) last saw the deceased alive on Sept. 16 , 1966, and that death occurred at 8:55 PM , from causes and on the date stated above.			
22a. DATE SIGNED 9/17/66			
22b. SIGNATURE <i>Clay R. Durrett</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) DR. CLAY DURRETT		22d. ADDRESS 236 VIRGINIA AVE.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 19, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Davis Memorial Cemetery
23d. LOCATION (City or Town) Cumberland Md. Allegany		(County) (State)	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge
ADDRESS		DATE SEP 22 1966	

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12119

CERTIFICATE OF DEATH

12114

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 62 DAYS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			d. STREET ADDRESS 700 LAFAYETTE AVENUE		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First JAMES	Middle P.	Last IRONS	4. DATE OF DEATH SEPTEMBER 14 1966
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED	8. NEVER MARRIED DIVORCED	9. DATE OF BIRTH 9-24-1905	10. AGE (In years 60 birthday) yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NON-ExMaintenance		10b. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (County & State, or foreign country) MARYLAND Cumberland	
13. FATHER'S NAME SILAS IRONS			14. MOTHER'S MAIDEN NAME STELLA SHIELDS		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-07-3204		17. INFORMANT MEMORIAL HOSPITAL -CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Kent Cancer Arrest</u> DUE TO (b) <u>Kimmelstiel Wilson Syndrome</u> YES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1934</u> , 19 to <u>Sept</u> , 1966, that (I) (we) last saw the deceased alive on <u>Sept 13</u> , 1966, and that death occurred at <u>4:10 A.M.</u> from causes and on the date stated above.					
22a. SIGNATURE <u>Dr. G. O. Himmelwright</u>			22b. DATE SIGNED <u>9/14/66</u>		
22c. PHYSICIAN'S NAME (Type) DR. G. O. HIMMELWRIGHT		22d. ADDRESS 133 VIRGINIA AVE., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 17, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park	
23d. LOCATION (City or Town) Cumberland, Md.			(County) (State) Allegany		
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.			ADDRESS		
25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
DATE SEP 22 1966					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12120

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12115

1. PLACE OF DEATH
a. COUNTY

ALLEGANY

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

FROSTBURG

c. LENGTH OF STAY IN 1b

D. O. A.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

MINERS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE

MARYLAND

b. COUNTY

ALLEGANY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

FROSTBURG

d. STREET ADDRESS

112 SPRING STREET

91-1

a. IS RESIDENCE
ON A FARM? YES NO

3. NAME OF
DECEASED
(Type or print)

First
JAMES

Middle
MUIR

Last
KERR

4. DATE
OF
DEATH
SEPTEMBER

Day
11, 1966
Year

5. SEX

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

9. AGE (in years
last birthday)

10. IF UNDER 1 YEAR

11. IF UNDER 24 HRS.

MALE

WHITE

WIDOWED

DIVORCED

DEC. 1, 1885

80

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

1DB. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT
COUNTRY?

DYE HOUSE

CELANESE CORP.

MARYLAND

U.S.A.

13. FATHER'S NAME

THOMAS KERR

14. MOTHER'S MAIDEN NAME

JEAN MUIR

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

NO

18. SOCIAL SECURITY NO.

214-01-3779

17. INFORMANT

Address

MRS. VIRGINIA KERR, FROSTBURG, MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CORONARY OCCLUSION

INTERVAL BETWEEN
ONSET AND DEATH
SUDDEN

4201
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO

(b)

CORONARY SCLEROSIS

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m.
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

BENEDICT SKITARELIC, M. D.

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

22. DATE SIGNED

RD 9,

Address (Street, city, town, or county) CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

23b. DATE THEREOF

SEPT. 13, 1966

23c. NAME OF CEMETERY OR CREMATORIUM

FBIG. MEMORIAL PARK

23d. LOCATION (City, town or county) (State)

FROSTBURG, MD.

24. FUNERAL DIRECTOR

ADDRESS

25a. REC'D BY REGISTRAR

DATE

25b. REGISTRAR'S SIGNATURE

SEP 19 1966

Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Chief Medical Examiner. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12116

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing (Rural)		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing (Rural)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS Knapps Meadow	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		a. NAME OF DECEASED (Type or print) JOHN LEAKE	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Dec, 31st. 1889	
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 0 Dey 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner		10b. KIND OF BUSINESS OR INDUSTRY (COAL)	
11. BIRTHPLACE (County & State, or foreign country) Clay County, Indiana		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Leake		14. MOTHER'S MAIDEN NAME Maude Winters	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Thomas Powers, Lonaconing, MD. (Daughter)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1538 Dehydration		7 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Intestinal Obstruction		21 days	
} DUE TO (c) Carcinoma large bowel		14 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) ACVD & congestive failure		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 20f. (City or town) (County) (County) (State) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 1966 to Sept. 6, 1966 , that (I) (we) last saw the deceased alive on Sept. 3, 1966 , and that death occurred at 5 A.M. from the causes and on the date stated above.		22b. DATE SIGNED 9-6-66	
22a. SIGNATURE M. R. Miles, M.D.		22b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) L.R. MILES, JR. M.D.		22d. ADDRESS LONACONING MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/8/1966	
23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park		23d. LOCATION (City, town or county) (State) Cumberland, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHORN		25a. REC'D BY REGISTRAR DATE SEP 7 1966	
ADDRESS Lonaconing, MD.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MANAGEMENT

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12122

CERTIFICATE OF DEATH

12117

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician. director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b MARYLAND	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RAWLINGS		d. STREET ADDRESS R.T. # 3 BOX 179	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HENRY ARNOLD LEASE		First HENRY	Middle ARNOLD
Last LEASE		4. DATE OF DEATH SEPTEMBER 26 1966	Month Day Year
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH 11-7-95		9. AGE (In years last birthday) 70 yrs.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane Operator		11. BIRTHPLACE (County & State, or foreign country) W.VA. Fort Ashby	
13. FATHER'S NAME GARRETT LEASE (D)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-07-6997	
17. INFORMANT Mrs. Pearl V. Lease, Rawlings, Md.		Address PT'S CHART	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease DUE TO (c) Diabetes mellitus DUE TO INTERVAL BETWEEN ONSET AND DEATH 6 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Generalized arteriosclerosis and osteoarthritis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 31, 1952 , to Sept. 26, 1966 , that (I) (we) last saw the deceased alive on Sept. 26, 1966 , and that death occurred at 6:20 PM M.M. from causes and on the date stated above.			
22c. SIGNATURE <i>James P. Hallinan M.D.</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. DATE SIGNED 9-27-66
22c. PHYSICIAN'S NAME (Type) DR. HALLINAN, M.D.		22d. ADDRESS 140 BEDFORD ST. CUMBERLAND MARYLAND.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/29/66	23c. NAME OF CEMETERY OR CREMATORIAL Mineral Chapel Baptist Cen. Nr. Ft. Ashby, Mineral, W.Va.
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Md.		ADDRESS	25a. REC'D BY REGISTRAR OCT 3 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

12122

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12118

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours of death.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)											
a. COUNTY Allegany		a. STATE Md.											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gilmore		b. COUNTY Allegany											
c. LENGTH OF STAY IN lb Minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route #36		d. ADDRESS Frostburg											
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. ADDRESS 137 Water Street											
3. NAME OF DECEASED (Type or print) Samuel M. Leptic		First	Middle										
4. DATE OF DEATH Sept. 4 1966		Month	Day										
5. SEX M		6. COLOR OR RACE W	7. MARRIED WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/>	8. NEVER MARRIED DIVORCED <input type="checkbox"/> <input checked="" type="checkbox"/>	9. DATE OF BIRTH July 1 1937	10. AGE (in years last birthday) 29 yrs.	11. IF UNDER 1 YEAR Months 0	12. IF UNDER 24 HRS. Days 0	13. IF UNDER 24 HRS. Hours 0	14. IF UNDER 24 HRS. Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Dept.		10b. KIND OF BUSINESS OR INDUSTRY Celanese Fibres		11. BIRTHPLACE (State or foreign country) Frostburg		12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Samuel Leptic		14. MOTHER'S MAIDEN NAME Helen Brown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes World War 2					16. SOCIAL SECURITY NO. 215-34-4340		17. INFORMANT Mrs. Don Adams, 137 Water St. Frostburg	Address Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. INTERVAL BETWEEN ONSET AND DEATH Minutes											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock													
8254 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													
DUE TO (b) DUE TO (c)		Fractured neck; Ruptured Liver					Minutes						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. EXTERNAL CAUSE WAS PRIMAR Y OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of auto in one car accident					20c. TIME OF INJURY Month, Day, Year Hour o.m. 5:10 Sept. 4 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Route # 36	20f. (City or town) Gilmore, Allegany, Maryland	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspectian <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							22. DATE SIGNED September 4, 1966						
ACTUAL SIGNATURE Benedict Skitarelic		MD.					EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify Burial)		23b. DATE THEREOF Sept. 7 1966		23c. NAME OF CEMETERY OR CREMATORIY Sunset Memorial Pk.		23d. LOCATION (City or Town) Cumberland Allegany Md.		(County) (State)					
24. FUNERAL DIRECTOR Hafer Funeral Home		ADDRESS Frostburg, Md.		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE SEP 8 1966							
25c. DATE SEP 8 1966													

1 M
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12124

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12119

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN lb LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 131 BOWERY STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HAROLD		First M.	Middle LEWIS
4. DATE OF DEATH Month SEPTEMBER Day 5, Year 1966			
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHIPPING DEPT.		9. B. DATE OF BIRTH FEB. 5, 1917	
10a. KIND OF BUSINESS OR INDUSTRY UNION CARBIDE		9. AGE (In years last birthday) 49 yrs.	
10b. BIRTHPLACE (State or foreign country) MARYLAND		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MOTHER'S MAIDEN NAME BESSIE MORGAN		12. FATHER'S NAME JOHN E. LEWIS	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		14. SOCIAL SECURITY NO. 217-10-5002	
15. DUE TO (b) self inflicted		16. INFORMANT RICHARD LEWIS, ROCKVILLE, MD.	
17. INTERVAL BETWEEN ONSET AND DEATH Sudden		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot of Head DUE TO (b) self inflicted DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED September 5, 1966	
23a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)
20f. (City or town) FROSTBURG, MD. (County) ALLEGANY (State) MARYLAND		21. ACTUAL SIGNATURE <i>Benedict Skitarelic, M.D.</i>	
22. EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		23. DATE THEREOF SEPT. 8, 1966	
24. BURIAL		23c. NAME OF CEMETERY OR CREMATORIAL FBIG. MEMORIAL PARK	
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.		23d. LOCATION (City or Town) FROSTBURG, MD. (County) ALLEGANY (State) MARYLAND	
25a. RECD BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE	
25c. DATE SEP 8 1966			

to our attention

(annual list)

and a unique
inflection

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12125

CERTIFICATE OF DEATH

12120

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

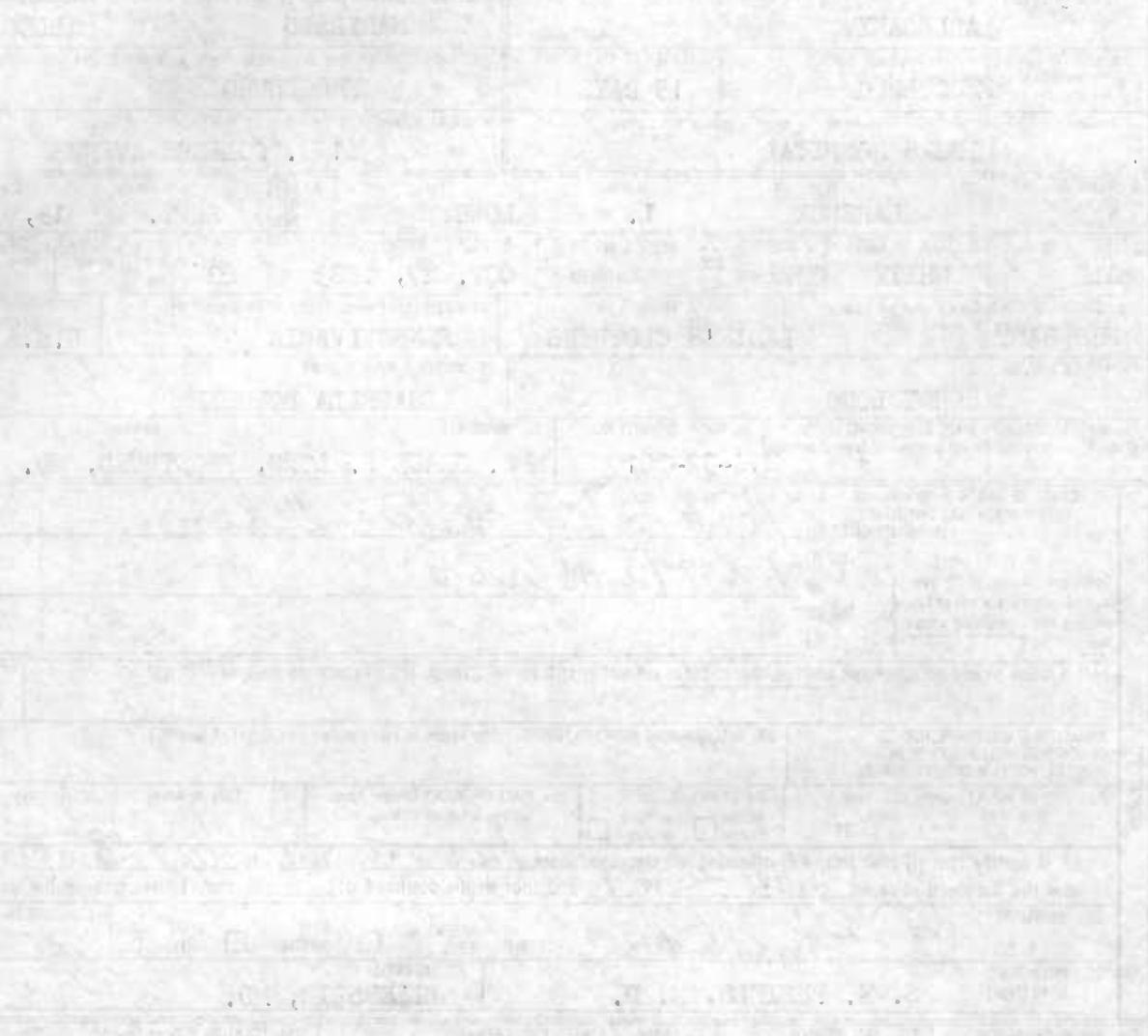
Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY ALLEGANY			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG			c. LENGTH OF STAY IN 1b 15 DAYS		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG			d. STREET ADDRESS 41 W. COLLEGE AVENUE		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) CLARENCE		First CLARENCE	Middle L.	Lost LONG	4. DATE OF DEATH Month SEPT. Day 13, Year 1966
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH OCT. 27, 1883	9. AGE (In years last birthday) 82 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT			10b. KIND OF BUSINESS OR INDUSTRY LADIE'S CLOTHING		11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA
13. FATHER'S NAME HENRY LONG			14. MOTHER'S MAIDEN NAME ISABELLA BOUCHER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 214-32-3019		17. INFORMANT Address MRS. GRACE P. LONG, FROSTBURG, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Perforated Gastric Ulcer.</i> DUE TO (b) <i>Peritonitis.</i> DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Day 27, 1966</i>	20f. (City or town) FROSTBURG	(County) (State) MARYLAND
21. I certify that (I) (this hospital) attended the deceased from Aug 27, 1966 , to Sept 15, 1966 , that (I) (we) last saw the deceased alive on Sept 12, 1966 , and that death occurred at M. from causes and on the date stated above.					
22a. SIGNATURE <i>S. E. Enfield</i>					
22c. PHYSICIAN'S NAME (Type) S. E. ENFIELD, M. D.		22d. ADDRESS ELLERSLIE, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF SEPT. 16, '66	23c. NAME OF CEMETERY OR CREMATORIAL FROSTBURG MEMORIAL PARK	23d. LOCATION (City or Town) FROSTBURG, MD.	(County) (State)
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.			ADDRESS	25a. REC'D BY REGISTRAR Charles J. George	25b. REGISTRAR'S SIGNATURE
DATE SEP 19 1966			DATE SEP 19 1966		

EXERCISE

STAGE TO STABILITY

EXERCISE



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT

12126

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12121

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal. File pages 1 and 2 with the State Department of Health within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 30 Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 208 Union Street		d. STREET ADDRESS 208 Union Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Vincent Paul Long		First Middle Last	4. DATE OF DEATH Month Day Year September 22 19 66
5. SEX Male White		6. COLOR OR RACE 7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH July 31, 1889		9. AGE (In years lost birthday) 77 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Employee-Celanese Corp of America		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Corp	
13. FATHER'S NAME Nelson Long		14. MOTHER'S MAIDEN NAME Mary E. Cahill	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-10-4971 Edgar Bucy	
17. INFORMANT Coronary Occlusion		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH Sudden DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. 4201 } (b) Coronary Sclerosis DUE TO (c) -----	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. -----		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED September 22, 1966	
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> September 22, 1966 Address (Street, city, town, or county) Cumberland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/24/66	
23c. NAME OF CEMETERY OR CREMATORIAL S.S. Peter & Paul Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland	
24. FUNERAL DIRECTOR H. Lee Silcox Cumberland Maryland 21502		25a. REC'D. BY REGISTRAR DATE SEP 26 1966	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

1964-1965

2151

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 M

12127

CERTIFICATE OF DEATH

12128

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 34 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			d. STREET ADDRESS 1401 OLDTOWN ROAD			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
50 3. NAME OF DECEASED (Type or print) ELWOOD		First ELWOOD	Middle Ellsworth	Lost LONGERBEAM	4. DATE OF DEATH SEPT. 26 1966	Month Sept.	Doy 26	Year 1966
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 28, 1906	9. AGE (In years lost birthday) 60 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. DAYS 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (County & State, or foreign country) HARPERS FERRY, W. VA.			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE W. LONGERBEAM			14. MOTHER'S MAIDEN NAME MARY PAINTER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16. SOCIAL SECURITY NO.			17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD. Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 024X DUE TO Father Harrelson his & After. f's INTERVAL BETWEEN ONSET AND DEATH days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. GASTRO INTESTINAL HEMORRHAGE, massive days			DUE TO (b) GASTRO INTESTINAL HEMORRHAGE, massive weeks			DUE TO (c) Duodenal Ulcer. weeks		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumt. Allegy Md.		
21. I certify that (I) (this hospital) attended the deceased from retired , 19, to 9/20/66 , 19, that (I) (we) last saw the deceased alive on 9/20/66 , 19, and that death occurred at P. M, from causes and on the date stated above.								
22a. SIGNATURE J. Mallon			22b. DATE SIGNED 9/20/66					
22c. PHYSICIAN'S NAME (Type) R. J. Williams			22d. ADDRESS Cumt. Allegy Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 29, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany		
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.			ADDRESS			25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge
						DATE OCT 3 1966		

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 4 Film G581 9/26/66 M

12128

CERTIFICATE OF DEATH

12128

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Pages 1 and 2 director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN b 2 DAYS XX	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 125 INDEPENDENCE ST.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First MR.	Middle MELVIN	Last C. LOVE
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/12/18
9. AGE (In years last birthday) 48 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) BUS DRIVER	11. BIRTHPLACE (County & State, or foreign country) PITTSBURGH. PA.	12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME CLYDE LOVE	14. MOTHER'S MAIDEN NAME MARGARET KING	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO. 220 10 0699	17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure, probably with terminal pulmonary embolus DUE TO 7545			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Congenital Heart Disease, specifically infundibular stenosis, with pulmonic hypertension DUE TO (c) and cor pulmonale			
INTERVAL BETWEEN ONSET AND DEATH 5 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Polycythemia, presumed secondary to heart disease and hypoxemia			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 3.35 Wm causes
20f. (City or town) 3.35 Wm		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 20, 1959 , to Sept. 12th, 1966 , that (I) (we) last saw the deceased alive on Sept. 12th, 1966 and that death occurred at 3.35 Wm causes and on the date stated above.			
22a. SIGNATURE <i>Wyand B. Doerner Jr.</i>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. Wyand B. Doerner Jr.	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) DR. WYAND DOERNER, Jr.		22d. DATE SIGNED 9-14-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF SEPT. 15, 1966	23c. NAME OF CEMETERY OR CREMATORIAL HILLCREST BURIAL PARK
23d. LOCATION (City or Town) CUMBERLAND, MD.		(County) (State)	
24. FUNERAL DIRECTOR BYRON KIGHT		25a. ADDRESS CUMBERLAND, MD.	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
20 M 1/66		DATE SEP 16 1966	

63132

43131

1941-1942

1942-1943

1943-1944

1944-1945

1945-1946

1946-1947

1947-1948

1948-1949

1949-1950

1950-1951

1951-1952

1952-1953

1953-1954

1954-1955

1955-1956

1956-1957

1957-1958

1958-1959

1959-1960

1960-1961

1961-1962

1962-1963

1963-1964

unknown

After river reached 1000 ft. in 1948, it was observed
that the water level was rising rapidly. In 1950
it reached 1000 ft. again. In 1952, it reached
1000 ft. again. In 1954, it reached 1000 ft.
again. In 1956, it reached 1000 ft.

After river reached 1000 ft. in 1948, it was observed that

the river

reached

1000 ft. in 1950

in 1952, it reached 1000 ft.

in 1954, it reached

1000 ft. in 1956

in 1958, it reached

1000 ft. in 1960

in 1962, it reached 1000 ft.

in 1964, it reached

1000 ft. in 1966

in 1968, it reached 1000 ft.

in 1970, it reached 1000 ft.

in 1972, it reached

1000 ft. in 1974

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12129

CERTIFICATE OF DEATH

12124

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)							
o. COUNTY ALLEGANY MARYLAND				o. STATE MARYLAND b. COUNTY ALLEGANY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 20 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS 509 EASTERN AVENUE							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				e. DATE Month SEPT Day 17 Year 19 66							
3. NAME OF DECEASED (Type or print)		First ANTHONY	Middle A	Lost LOWERY	4. DATE OF DEATH						
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> X WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-14-1877				9. AGE (In years to 88 birthday) yrs.	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Employee of Baking Company			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) PENNA.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME ANTHONY LOWERY				14. MOTHER'S MAIDEN NAME MARY BAKER							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 212-24-0681			17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4500</i> <i>Chronic congestive heart failure</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Quint arteriosclerosis</i>											
DUE TO (c) <i>4500</i> <i>Quint arteriosclerosis</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>4500</i>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>4500</i>								
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m. <input type="checkbox"/>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Centerville (County) Bedford (State) Penna.			
21. I certify that (I) (this hospital) attended the deceased from 8-30 , 1966, to 9-17 , 1966, that (I) (we) last saw the deceased alive on 8-17 , 1966, and that death occurred at 2:30 PM , causes and on the date stated above.										22b. DATE SIGNED <i>9/22/66</i>	
22a. SIGNATURE <i>William P. James</i>										M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) DR. W P JAMES			22d. ADDRESS 441 N CENTRE ST. CUMBERLAND, MD.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/20/66		23c. NAME OF CEMETERY OR CREMATORIUM Bethel Cemetery			23d. LOCATION (City or Town) (County) (State) Centerville Bedford Penna				
24. FUNERAL DIRECTOR H. Lee Silcox Cumberland Maryland 21502					ADDRESS 25a. REC'D BY REGISTRAR SEP 22 1966					25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12130

CERTIFICATE OF DEATH

13507

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 15 DAYS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) AGNES		First	Middle	4. DATE OF DEATH SEPT. 28 1966	Month Doy Year
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-2-1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) MARYLAND <i>Lonaconing</i>	
13. FATHER'S NAME HUGH MCMILLAN		14. MOTHER'S MAIDEN NAME JENNIE E. SHOCKLEY		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brown pleuromedula				INTERVAL BETWEEN ONSET AND DEATH 15 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 6000		DUE TO Congestion of lungs		15 days	
		DUE TO Renal failure due Pyelonephritis & nephrosclerosis		15 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Thromboembolitis LLC, post op of a possible pulmonary				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Sept 13, 1966			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 59 GREENE ST.	
21. I certify that (I) (this hospital) attended the deceased from Sept 13, 1966 to Sept 28, 1966 , that (I) (we) last saw the deceased alive on Sept 28, 1966 , and that death occurred at 10:45 PM , from causes and on the date stated above.				22b. DATE SIGNED Oct 10, 1966	
22a. SIGNATURE Jennies e. weisman		M.D. <input type="checkbox"/> ATTENDING PHYS. DR. S. G. WEISMAN		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN		22d. ADDRESS 59 GREENE ST.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF October 1, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Davis Memorial Cem.	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS		25a. REC'D BY REGISTRAR Charles Judge	
				25b. REGISTRAR'S SIGNATURE	

1325

PLACE TO FORWARD

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1325

QUALITY

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12131

CERTIFICATE OF DEATH

13569

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,		c. LENGTH OF STAY IN lb 2 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 309 OLDTOWN RD.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First MARY	Middle L. (Lee)	Last METZ
4. DATE OF DEATH SEPT. 30 1966	Month SEPT.	Doy 30	Year 1966
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 10-22-1940	9. AGE (In years b. Month (birthday) 25 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. DAYS 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Art Teacher	10b. KIND OF BUSINESS OR INDUSTRY Public School	11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.	12. CITIZEN OF WHAT COUNTRY U. S. A.
13. FATHER'S NAME CHARLES D. CALLIS	14. MOTHER'S MAIDEN NAME FRANCES L. DOWLING	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO.	17. INFORMANT	Address MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Vertebrae fracture</i> — DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 224 X (b) <i>Phaeochromocytoma - Bilateral</i> WK. DUE TO (c) <i>Carcinoma</i> 2 hrs.			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1068 NATIONAL HIGHWAY
20f. (City or town) 1068 NATIONAL HIGHWAY		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1966 to 1966 , that (I) (we) last saw the deceased alive on 9/30 1966 , and that death occurred at 9:17 PM , from causes and on the date stated above.			
22a. SIGNATURE <i>Charles L. Mould, M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 10/1/66
22c. PHYSICIAN'S NAME (Type) DR. L. L. MOULD		22d. ADDRESS 1068 NATIONAL HIGHWAY	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 3, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park	23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.	ADDRESS	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge
VR A15 (4) 20 M 1/66		DATE OCT 10 1966	

1821

REINHOLD H. PEASE

1821

1821

GRADUATION

1821

GRADUATION

1821

GRADUATION

GRADUATION

GRADUATION

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GRADUATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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12132

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH
12125

Item #7 Film #1351 10/6/66 pg

1. PLACE OF DEATH
a. COUNTY

ALLEGANY

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

CUMBERLAND

c. LENGTH OF STAY IN 1b

40 YEARS

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

211 FULTON STREET

3. NAME OF
DECEASED
(Type or print)

First
RUTH

Middle
B.

Last
MILLER

4. DATE
OF
DEATH

SEPT. 30 1966

Month

Day Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (in years
last birthday)

10. IF UNDER 1 YEAR

11. IF UNDER 24 HRS.

FEMALE

WHITE

WIDOWED

DIVORCED

SEPT. 9, 1891

75

YRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

10b. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT
COUNTRY?

HOUSEWIFE

OWNHOME

MARYLAND

USA

13. FATHER'S NAME

HORACE G. BUCHANAN

14. MOTHER'S MAIDEN NAME

DELILAH DeVORE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

NO

NONE

GRACE WELTMAN

ELLERSLIE, MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4201

DUE TO

Conditions, If any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO

(c)

Acute Coronary Thrombosis
Myocarditis & Decompensation

INTERVAL BETWEEN
ONSET AND DEATH

Acute
6 min

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)
(County)
(State)

19

21. I certify that (I) (this hospital) attended the deceased from *July 20, 1966* to *Sept. 30, 1966*, that (I) (we) last
saw the deceased alive on *Sept. 26, 1966*, and that death occurred at *8 AM*, from the causes and on the date stated above.

22b. DATE SIGNED

22a. SIGNATURE

Clay E. Durrett

M.D. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. SEPT. 30, 1966

22c. PHYSICIAN'S NAME (Type)

CLAY E. DURRETT, M.D.

22d. ADDRESS

236 MARYLAND AVE. CUMBERLAND, MD.

23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION (City, town or county) (State)

BURIAL

OCT. 2, 1966

COOKS MILLS CEMETERY

ELLERSLIE, MD.

24. FUNERAL DIRECTOR

BYRON KIGHT

ADDRESS
CUMBERLAND, MD.

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE

OCT 3 1966 *Charles Judge*

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12138

CERTIFICATE OF DEATH

12126

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital			d. STREET ADDRESS 8 Furnace Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) JOSEPH H. MORTON		First	Middle	Lost	4. DATE OF DEATH 9/15/1966	Month Doy Year 19
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	B. DATE OF BIRTH 10/28/1889	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Doy Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Celanese Employee		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Lonaconing, MD.		12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME John Morton		14. MOTHER'S MAIDEN NAME Elizabeth Crosser				- Address
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-5641-A.		17. INFORMANT Mrs. Jean Steele, Lonaconing, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 442X Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last.		DAUGHTER Chronic Congestive Heart failure arteriosclerotic Cardiovascular end disease years -				INTERVAL BETWEEN ONSET AND DEATH 4 months
DUE TO (b) DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)				
20c. TIME OF INJURY Month, Doy, Year Hour o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Lonaconing	(County) Allegany	(State) MD.
21. I certify that (I) (this hospital) attended the deceased from June 1966, to Sept. 15, 1966 that (I) (we) last saw the deceased alive on Sept. 15 1966, and that death occurred at 9:30 A.M. from causes and on the date stated above.						22b. DATE SIGNED 9/16/66-
22c. PHYSICIAN'S NAME (Type) John B. Davis		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS Frostburg, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/18/1966	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Oak Hill Cemetery	23d. LOCATION (City or Town) Lonaconing, MD.	(County)	(State)
24. FUNERAL DIRECTOR GEORGE EICHORN		ADDRESS Lonaconing, MD.		25a. REC'D BY REGISTRAR DATE SEP 10 1966	25b. REGISTRAR'S SIGNATURE Charles Juge	

25151

25151

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12134

CERTIFICATE OF DEATH

12127

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) David		First E.	Middle Moses
4. DATE OF DEATH September 20 1966	Month September	Day 20	Year 1966
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH 2/12/1899	9. AGE (In years lost birthday) 67 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. DAYS 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Salesman	10b. KIND OF BUSINESS OR INDUSTRY Morton Garage	11. BIRTHPLACE (County & State, or foreign country) Lonaconing, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James Moses	14. MOTHER'S MAIDEN NAME Agnes McNeil	Address Barton, Md.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Felicit Moses	Address Barton, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Ischemia		"Wife" INTERVAL BETWEEN ONSET AND DEATH years	
DUE TO ACVD			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Pulmonary Fibrosis			
DUE TO Emphysema			
DUE TO Sept 20 1966			
DUE TO 1966			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Sept 20 1966		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Sept 20 1966	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Sept 20 1966
20f. (City or town) (County) (State) Sept 20 1966			
21. I certify that (I) (this hospital) attended the deceased from Sept 20 1966 , to Sept 20 1966 , that (I) (we) last saw the deceased alive on Sept 20 1966 , and that death occurred at 11 P.M. from causes and on the date stated above.		22b. DATE SIGNED 9-22-66	
22a. SIGNATURE L.R. MILES JR. MD		22b. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> Sept 20 1966	
22c. PHYSICIAN'S NAME (Type) L.R. MILES JR. MD		22d. ADDRESS LONACONING MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/23/66	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Laurel Hill Cemetery
24. FUNERAL DIRECTOR George Eichhorn		23d. LOCATION (City or Town) (County) (State) Moscow, A. Md.	
		25a. REC'D BY REGISTRAR SEP 26 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE M
HEALTH DEPT.

12135

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12128

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in 5 hours. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg, MD. (Shaft, Rural)						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) CANDACE		First MYERS	Middle Last					
4. DATE OF DEATH 9/12/1966		Month	Day Year					
5. SEX Female		6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 10/3/1869	9. AGE (In years last birthday) 96 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. KIND OF BUSINESS OR INDUSTRY		12. BIRTHPLACE (State or foreign country) Westernport, MD.		13. CITIZEN OF WHAT COUNTRY? USA.		
13. FATHER'S NAME Nelson Meese		14. MOTHER'S MAIDEN NAME Mary Sigler		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		
17. INFORMANT Mrs. Ada Philpot		18. ADDRESS Shaft, MD.		19. INFORMANT (Grandchild)		20. INTERVAL BETWEEN ONSET AND DEATH Months		
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) stating the underlying cause (c) lost.		22. DUE TO Chronic Myocarditis		23. DUE TO Arteriosclerotic Cardiovascular disease --				
24. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Fracture of Left Hip, Terminal Pneumonia		25. 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		26. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Sylvan Retreat, Cumberland, Alleg. Md.		27. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
28. 20c. TIME OF INJURY Month, Day, Year Hour a.m. 5:00 AM July 31¹⁹ 66		29. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		30. 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Sylvan Retreat, Cumberland, Alleg. Md.		31. 20f. (City or town) (County) (State) Cumberland, Alleg. Md.		
32. 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		33. ACTUAL SIGNATURE Benedict Skitarelic		34. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		35. 22. DATE SIGNED Sept. 12, 1966		
36. EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		37. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		38. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		39. ADDRESS (Street, city, town, or county) Cumberland, Md.		
40. 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		41. 23b. DATE THEREOF 9/14/1966		42. 23c. NAME OF CEMETERY OR CREMATORIAL Laurel Hill Cemetery		43. 23d. LOCATION (City or Town) (County) (State) Moscow, MD.		
44. 24. FUNERAL DIRECTOR GEORGE EICHORN		45. ADDRESS Lonaconing, MD.		46. 25a. REC'D. BY REGISTRAR DATE SEP 14 1966		47. 25b. REGISTRAR'S SIGNATURE Charles Judge		

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #14 & 17 Film #G381 10/3/66 pc

CERTIFICATE OF DEATH

12129

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

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12136

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
a. COUNTY Allegany MARYLAND		a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b Years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 224 Glenn St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Russell Samuel Middle Russell Nave		4. DATE OF DEATH Month 9 Day 23 Year 1966	
4. DATE OF DEATH Month 9 Day 23 Year 1966		5. SEX M	
6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 8/22/00		9. AGE (In years 66 (last birthday) yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11. BIRTHPLACE (County & State, or foreign country) Bedford Co., Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Nave		14. MOTHER'S MAIDEN NAME Anna Tewell Edith Josephine Carr	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-07-3076	
17. INFORMANT Carr Address Mrs. Edith Nave 224 Glenn St Cumberland, Md patient's chart		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
(b) DUE TO (c)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Sept 23 1966 to Sept 25 1966 that (I) (we) last saw the deceased alive on Sept 23 1966, and that death occurred at 5 A.M. from causes and on the date stated above.	
22a. SIGNATURE W G Spiggle		22b. DATE SIGNED Sept 25, 1966	
22c. PHYSICIAN'S NAME (Type) W G Spiggle		22d. ADDRESS 126 N. Smallwood St Cumberland, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 26, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Near Cumberland Allegany, Md.	
24. FUNERAL DIRECTOR John J. Hafer, Jr.		25a. ADDRESS	
John J. Hafer, Jr. 230 Balto Ave Cumberland, Md		25b. REGISTRAR'S SIGNATURE SEP 27 1966 Charles Judge	

PS18

PS18

11/11/1980

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12137

CERTIFICATE OF DEATH

12130

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Frostburg		e. STATE Maryland b. COUNTY Allegany	
c. LENGTH OF STAY IN lb				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Miners Hospital		Lonaconing	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
ELIZABETH				OLEWINE	9/11/1966
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 90 yrs.
Female		White		JAN, 1876	10. IF UNDER 1 YEAR Months Deys Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY
Retired Saleslady			Lonaconing	USA

13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
Joseph Jones		Elizabeth Fatkins		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No			JEANETTE JOHNSON, Rockville, MD.	

18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)		7 days
4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		weeks
DUE TO (c) ACVD		years
Congestive failure		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)		19. WAS AUTOPSY PERFORMED?
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		YES <input type="checkbox"/> NO <input type="checkbox"/>

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
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21. I certify that (I) (this hospital) attended the deceased from 1957 to Sept. 11, 1966 that (I) (we) last saw the deceased alive on Sept. 10, 1966, and that death occurred at 3 A.M. from the causes and on the date stated above.						
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22a. SIGNATURE <i>L R Miles MD</i>	M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 9/12/66
22c. PHYSICIAN'S NAME (Type) L R MILES VR		22d. ADDRESS Lonaconing MD			

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/13/1966	23c. NAME OF CEMETERY OR CREMATORIAL Oak Hill Cemetery	23d. LOCATION (City, town or county) Lonaconing, MD.	(State)
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24 FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHORN	ADDRESS Lonaconing, MD.	25a. REC'D. BY REGISTRAR SEP 13 1966	25b. REGISTRAR'S SIGNATURE j Charles Judge
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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12138

CERTIFICATE OF DEATH

12131

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 16 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			d. STREET ADDRESS 503 EICHNER AVE.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ORPHEA	Middle	Last PATTON	4. DATE OF DEATH	Month SEPT	Day 17	Year 1966
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-11-88	9. AGE (In years last birthday) 78 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) GARRETT CO, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Mahlon MALLIN MILLER			14. MOTHER'S MAIDEN NAME ANNA FULLER Eichorn			Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Abdominal Hemorrhage</i> DUE TO <i>Leision in Colon</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Leision in Colon</i> (c) <i>—</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. — 19 p.m. —		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State) <i>Camp Alley Rd</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>4/22/66</i> , 19 <i>—</i> , to <i>8/17/66</i> , 19 <i>—</i> , that (I) <i>we</i> lost saw the deceased alive on <i>9/17/66</i> , 19 <i>—</i> , and that death occurred at <i>3:35M</i> , <i>PM</i> causes and on the date stated above.							22b. DATE SIGNED <i>9/15/66</i>
22a. SIGNATURE <i>R. J. Williams</i>		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>9/15/66</i>	
22c. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS		22d. ADDRESS 122 S CENTRE ST. CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>9/20/66</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Grantsville Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Grantsville, Garrett, Md.</i>	
24. FUNERAL DIRECTOR <i>Don Newman</i>		ADDRESS <i>Grantsville, Md.</i>					
		25a. REC'D BY REGISTRAR <i>Charles Judge</i>					
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12139

CERTIFICATE OF DEATH

12133

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to a burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland Rt #1 Bx 503		c. LENGTH OF STAY IN lb 4 Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland Rt #1 Box 503	
3. NAME OF DECEASED (Type or print) Ada Belle Phillips		4. DATE OF DEATH September 21, 1966	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Jan 11, 1900
9. NEVER MARRIED <input type="checkbox"/>	10. DIVORCED <input type="checkbox"/>	11. AGE (In years lost birthday) 66 yrs.	12. IF UNDER 1 YEAR Months Doy Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY At Home	
13. FATHER'S NAME Leonadus Pardew		14. MOTHER'S MAIDEN NAME Mary Hamilton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 161-32-9679	
17. INFORMANT Leslie C. Phillips		18. INTERVAL BETWEEN ONSET AND DEATH one yr	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>metastatic carcinoma, gen'l</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Adeno Ca of breast</i> DUE TO (c) <i>2-3 yrs</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Aug 20</i> , 1966, to <i>Sept 24, 1966</i> that (I) (we) last saw the deceased alive on <i>Aug 20</i> 1966, and that death occurred at <i>1:00 AM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>A. J. Mirkin</i>		22b. DATE SIGNED 9-24-66	
22c. PHYSICIAN'S NAME (Type) Dr. A. J. MIRKIN		22d. ADDRESS 115 So. Cembre St - Cumberland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/26/66	
23c. NAME OF CEMETERY OR CREMATORIAL Chaneyville Cemetery		23d. LOCATION (City or Town) (County) (State) Chaneyville Bedford Penna	
24. FUNERAL DIRECTOR H. Lee Silcox		ADDRESS Cumberland Maryland 21502	25a. REC'D BY REGISTRAR DATE SEP 27 1966
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12140

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12134

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and return to me within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS 104 Park Street	
3. NAME OF DECEASED (Type or print) Willis C. Pollock		First	Middle
4. DATE OF DEATH Sept 17 1966	Month	Doy	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED
8. DATE OF BIRTH August 11, 1890	9. AGE (In years lost birthday) 76 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Dys Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Foreman		10b. KIND OF BUSINESS OR INDUSTRY B & O RR	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Charles C. Pollock		14. MOTHER'S MAIDEN NAME Stella Iva Steele	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-385-3398	17. INFORMANT Carroll Carroll Pollock
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause { lost. (b) DUE TO (c) DUE TO		Address 211 Griffith Drive Douglasville, Pa.	
Coronary Thrombosis, left		INTERVAL BETWEEN ONSET AND DEATH Sudden	
Coronary Sclerosis, generalized		----	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Myocardial Infarctions, old			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 18, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park
24. FUNERAL DIRECTOR John J. Hafer		ADDRESS John J. Hafer 230 Balto. Ave. Cumberland, Md.	25a. LOCATION (City or Town) (County) (State) Near Cumberland, Md.
25b. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE SEP 20 1966	

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

12141

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12135

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and fill any event within 72 hours after death.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
a. COUNTY Allegany		a. STATE MARYLAND b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 60 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 1008 Ella Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D. O. A. Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Walter Cornelius Price		First	Middle
4. DATE OF DEATH Sept. 8 1966		Lost	Month
5. SEX Male		5. COLOR OR RACE White	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
7. KIND OF BUSINESS OR INDUSTRY Government		8. DATE OF BIRTH July 31, 1897	
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railway Postal Clerk		11. BIRTHPLACE (State or foreign country) Sandy Hook, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Winfield S. Price	
14. MOTHER'S MAIDEN NAME Clara M. Downs		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes War I 11 Korean	
16. SOCIAL SECURITY NO. 4201		17. INFORMANT Mr. William W. Price, Cumberland, Md. Son	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion		Address 4201	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Coronary Sclerosis		INTERVAL BETWEEN ONSET AND DEATH sudden	
DUE TO Coronary Sclerosis		----	
DUE TO Coronary Occlusion			
DUE TO Coronary Occlusion			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Cumberland		(County) Allegany	
(State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED Sept. 8, 1966	
ACTUAL SIGNATURES Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 10, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. ADDRESS	
25b. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE SEP 13 1966		DATE SEP 13 1966	

FOR STATE
HEALTH DEPT.

is necessary,
please execute
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 24 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 12 Hrs.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First LeRoy	Middle Adolphus	Last Propst	4. DATE OF DEATH Sept. 29 1966	Month Year	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 10, 1902	9. AGE (In years last birthday) 64 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Hours	12. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Track Foreman		10b. KIND OF BUSINESS OR INDUSTRY W.Md. Railroad		11. BIRTHPLACE (State or foreign country) Moore, Tucker Co. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alfred Floyd Propst		14. MOTHER'S MAIDEN NAME Mary Ellen Huffman		Address Brooks E. Evans, Kitzmiller, Md.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> NO		16. SOCIAL SECURITY NO. 705-10-6050-		17. INFORMANT Shock		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 451X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) Ruptured abdominal arteriosclerotic aneurysm	
						INTERVAL BETWEEN ONSET AND DEATH Hours	
						Hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Coronary Sclerosis, Marked							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> September 29, 1966		DATE SIGNED			
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		Address (Street, city, town, or county) Cumberland, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 2, 1966		22c. NAME OF CEMETERY OR CREMATORIAL Garrett Co. Memorial Gardens- Oakland, Md.		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR Amy Mildred Sharpless P.O. Kitzmiller, Md.		ADDRESS Blaine, W.Va.		24a. REC'D BY REGISTRAR OCT 3 1966		24b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12137

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN lb 14 DAYS					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
51		d. STREET ADDRESS 102 JACKSON STREET					
3. NAME OF DECEASED (Type or print) MARGARET		First E.	Middle RAVENS CROFT				
S. SEX FEMALE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH FEB. 1, 1915				
6. COLOR OR RACE WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 51 yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAITRESS		10b. KIND OF BUSINESS OR INDUSTRY RESTAURANT	11. BIRTHPLACE (County & State, or foreign country) MARYLAND				
13. FATHER'S NAME FRANK W. RALEY		14. MOTHER'S MAIDEN NAME CLARA A. MILLER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 220-16-6749	17. INFORMANT Address HILLARY RAVENS CROFT, LONACONING, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic myocardial failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Hypertensive heart disease</i> (b) <i>Hypertensive heart disease</i> DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MEDICAL CERTIFICATION		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
		20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> or at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> or at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Sept. 30, 1966</i> to <i>Sept. 14, 1966</i> that (I) (we) last saw the deceased alive on <i>Sept. 14, 1966</i> , and that death occurred at <i>1050 P.M.</i> from causes and on the date stated above.				22b. DATE SIGNED <i>9/15/66</i>			
22c. PHYSICIAN'S NAME (Type) A. P. STRONG, M. D.		22d. ADDRESS E. MAIN ST., FROSTBURG, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9-17-66		23c. NAME OF CEMETERY OR CREMATORIAL FROSTBURG G. MEMORIAL PARK		23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.	
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
B P		DATE SEP 19 1966					
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12144

CERTIFICATE OF DEATH

12138

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pages 1 and 2 Cumberland		b. COUNTY Allegany	
c. LENGTH OF STAY IN lb 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		d. STREET ADDRESS 827 Mt. Royal Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Harry		First Francis	Middle Reinhart
4. DATE OF DEATH Month 9	Month 20	Doy 1966	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 8/10/77
9. AGE (In years lost birthday) 89 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. DAYS 0	12. IF UNDER 24 HRS. Hours 0
100. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor retired	10b. KIND OF BUSINESS OR INDUSTRY Kelly Tire Plant	11. BIRTHPLACE (County & State, or foreign country) Cumberland, Allegany Co., Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Francis Reinhart	14. MOTHER'S MAIDEN NAME Mary A. Downey	Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 215-12-7228-A	17. INFORMANT patient's chart	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 week UNK unKnown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Myocardial infarction Antecardiac Metastatic hypertension		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1967 , to 9/20, 1966 , that (I) (we) last saw the deceased alive on 9/19, 1966 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE Alvessuer		22b. DATE SIGNED 9/22/66	
22c. PHYSICIAN'S NAME (Type) S. G. Weisman, M.D.		22d. ADDRESS 59 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/22/66	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS SS. Peter & Paul Cemetery
24. FUNERAL DIRECTOR H. Wayne George		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.	
25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE	
26. DATE SEP 26 1966			

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT

12145

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12139

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, or in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb DOA	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 318 Bedford St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harry		First N.	Middle Rice
4. DATE OF DEATH 9 27 1966		Lost	Month
S. SEX M	6. COLOR OR RACE W	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH April 18, 1889		9. AGE (In years lost birthday) 77 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Union Laundry Employee		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Cumberland Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John N. Rice		14. MOTHER'S MAIDEN NAME Olive Francis North	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-05-7712A	
17. INFORMANT Mrs. Hazel K. Rice		Address 318 Bedford St Cumberland, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH Sudden			
4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Sclerosis DUE TO (c) ----- DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> September 27, 1966 Address (Street, city, town, or county) Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/30/66	23c. NAME OF CEMETERY OR CREMATORIAL Rosehill Cemetery
24. FUNERAL DIRECTOR Dale L. Merritt		ADDRESS Cumberland Maryland 21502	25a. REC'D BY REGISTRAR DATE SEP 29 1966
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with
 Page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 12140

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. # 4 Cumberland,		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. # 4 Cumberland,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brice Hollow Rd.		d. STREET ADDRESS Brice Hollow Rd.	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Herbert		First Wade	Middle Last Rice
4. DATE OF DEATH Sept. 5, 1966	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 30, 1894
9. AGE (In years last birthday) 72	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. farmer	11. BIRTHPLACE (State or foreign country) Twiggstown, Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Millard E. Rice		14. MOTHER'S MAIDEN NAME Sarah V. Rice	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. 220-34-1434	17. INFORMANT Mrs. Ruth Rice Rt. # 4 Cumberland, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Advanced Coronary Insufficiency		INTERVAL BETWEEN ONSET AND DEATH sudden	
DUE TO Generalized atherosclerosis (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Stokes-Adams Syndrome		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Doy, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8:31:66		7.3. 1959, to 9.5. 1966	ADDRESS (Street, city or town, state) 441 N. Centre St Cumberland, Maryland
olive on		DATE SIGNED 9.6.66	
ACTUAL SIGNATURE William P. James			
PHYSICIAN'S NAME (Type) William P. James, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 9/8/66	22c. NAME OF CEMETERY OR CREMATORIAL Mount Pleasant Cemetery	22d. LOCATION (City, town, or county) (State) Nr. Cumberland, Allegany Md.
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George Cumberland, Maryland		ADDRESS	24a. REC'D BY REGISTRAR DATE SEP 9 1966
			24b. REGISTRAR'S SIGNATURE Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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12147

CERTIFICATE OF DEATH

12141

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 8/13/1966		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		01-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary				d. STREET ADDRESS Rt. #1, Valley Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sterling Ward Ryan		First	Middle	Lost	4. DATE OF DEATH September 12, 1966	Month	Day Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/24/1885	9. AGE (In years lost birthday) 80 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired: Tire Worker		10b. KIND OF BUSINESS OR INDUSTRY Kelly Tire Plant		11. BIRTHPLACE (County & State, or foreign country) West Virginia, St. George		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME Daniel Webster Ryan				14. MOTHER'S MAIDEN NAME Tabitha Hester Parsons			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-07-1145		17. INFORMANT PO BOX 6999 Mrs. Delta Ryan		Address Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>① Hypertension, Ch. degeneration</u> 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO <u>② Arterio Sclerosis & Hypertension</u> (b) <u>③ Parkinson Disease, second.</u> DUE TO <u>④ Bilateral Lateral</u> (c) <u>⑤ Incentive of Bowel & Bladder.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> Not work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/13/66, 19, to 9/12/66, 19, that (I) (we) last saw the deceased alive on 9/10/66 19, and that death occurred at A. M, from causes and on the date stated above							
22a. SIGNATURE <u>Mathews</u>		at 11:00 A.M. M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) Lee B. Mathews, M. D.		22d. ADDRESS 49 Greene St., Cumberland, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/15/66		23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.	
24. FUNERAL DIRECTOR H. Wayne George		ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DATE SEP 16 1966		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

СЕГЕД

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

12148 MARYLAND
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1 MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12142

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG	
c. LENGTH OF STAY IN 1D LIFE		d. STREET ADDRESS 196 W. MECHANIC ST.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MINERS HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First MARY	Middle K.	Last SATHOFF
4. DATE OF DEATH Month SEPT.	Month 30,	Day 19	Year 66
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH MAY 13, 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CONRAD BRODE		14. MOTHER'S MAIDEN NAME RACHEL KIRKWOOD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 217-28-7676	
17. INFORMANT MRS. JOSEPH LEWIS, FROSTBURG, MD.		Address 39 W. FIRST ST.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
DUE TO Coronary Occlusion		--	
DUE TO Coronary Sclerosis		--	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M. D.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22. DATE SIGNED			
Address (Street, city, town, or county) RD 1, CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT. 3, 1966	
23c. NAME OF CEMETERY OR CREMATORY FBI G. MEMORIAL PARK		23d. LOCATION (City, town or county) (State) FROSTBURG, MD.	
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.		ADDRESS	
25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE	
DATE OCT 5 1966			

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12149

CERTIFICATE OF DEATH

12148

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 56 years		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital						d. STREET ADDRESS 129 Arch Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary		First Middle Elizabeth		Last Schultz		4. DATE OF DEATH September 17 1966			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 5-4-10		9. AGE (In years last birthday) 56 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Cumberland		12. CITIZEN OF WHAT COUNTRY? Allegany, Maryland		13. FATHER'S NAME John Whitman (D)	
14. MOTHER'S MAIDEN NAME Kathern (Smit) Whitman (D)		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO.		17. INFORMANT Patients Chart		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1750		DUE TO Carcinosarcoma - Ovary						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Abcess of Femoral Canal									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 8-20 1966 , to 9-17 1966 , that (I) (we) last saw the deceased alive on 9-17 1966 , and that death occurred at 11 A.M. from causes and on the date stated above.									
22a. SIGNATURE John G. Gandy		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8-20-66	
22c. PHYSICIAN'S NAME (Type) L. Michael Gandy		22d. ADDRESS 120 N. Smallwood							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 19, 1966		23c. NAME OF CEMETERY OR CREMATORIAL St. Mary's Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany			
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS		25a. REC'D BY REGISTRAR SEP 26 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

22151

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22151

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12150

CERTIFICATE OF DEATH

12144

1. PLACE OF DEATH
a. COUNTY

ALLEGANY

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

LONA CONING

c. LENGTH OF STAY IN 1b

27 MONTHS

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

KYLE NURSING HOME

3. NAME OF
DECEASED
(Type or print)

First
GEORGE

Middle
W.

Last
SCHURG

4. DATE
OF
DEATH
SEPT.

15, 1966

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

OCT. 1, 1888

9. AGE (In years
last birthday)

77 yrs.

10. IF UNDER 1 YEAR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

MINER

10b. KIND OF BUSINESS OR
INDUSTRY

COAL

11. BIRTHPLACE (County & State, or foreign country)

DEAL, PENNSYLVANIA

12. CITIZEN OF WHAT
COUNTRY?

U.S.A.

13. FATHER'S NAME

CARL SCHURG

14. MOTHER'S MAIDEN NAME

JULIA DELBROOK

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

NO

16. SOCIAL SECURITY NO.

216-10-6806

17. INFORMANT

MR. HARRY SCHURG, 1231 NATIONAL HGHY.

Address LAVALE, MD.

NATIONAL HGHY.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

493 x *Pneumonia*

OUT TO

Conditions, If any, which
gave rise to Immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

3 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

Arteriosclerotic CVD disease & congestive failure

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING

OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.

19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from

1964, to Sept. 15, 1966, that (I) (we) last

saw the deceased alive on Sept. 14, 1966, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE

Leslie R. Miles, M.D.

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

DATE SIGNED
9-17-66

22c. PHYSICIAN'S
NAME (Type)

LESLEI R. MILES, M.D.

22d. ADDRESS

STATE ROAD, LONA CONING, MD.

23a. BURIAL, CREMATION,
REMOVAL (Specify)

BURIAL

23b. DATE THEREOF

SEPT. 18, 1966

23c. NAME OF CEMETERY OR CREMATORIAL

FROSTBURG MEM. PARK

23d. LOCATION (City, town or county)

FROSTBURG, MARYLAND

24a. FUNERAL DIRECTOR

Marilou M. Sowers

24b. ADDRESS

HAFER FUNERAL HOME

60 W. MAIN ST. FROSTBURG

25a. REC'D BY REGISTRAR

SEP 22 1966

25b. REGISTRAR'S SIGNATURE
Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12151

CERTIFICATE OF DEATH

12145

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FAIRHOPE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First GLADYS	Middle C.	Lost SHAFFER	4. DATE OF DEATH	Month SEPTEMBER	Doy 13	Year 1966
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-2-93	9. AGE (In years lost birthday) 72 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. DAYS 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) HYNDMAN, PA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN SHOUP			14. MOTHER'S MAIDEN NAME LAURA CLITES			Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 78-12-4741		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident & left</i> INTERVAL BETWEEN ONSET AND DEATH <i>331X</i> 331X DUE TO (b) <i>Arteriosclerosis</i> herniplegia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION, GIVEN IN PART I (o) <i>Coronary Insufficiency, Osteoarthritis</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 615		20f. (City or town) (County) (State) 7/13, 1966	
21. I certify that (I) (this hospital) attended the deceased from 6/21 to 7/13 , 1966, that (I) (we) last saw the deceased alive on 6/21 , 1966, and that death occurred at 7:45 A.M. from causes and on the date stated above.							
22a. SIGNATURE <i>Leo H. Ley Jr</i>							
22c. PHYSICIAN'S NAME (Type) DR. LEO LEY		22d. ADDRESS CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 1 6, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Hyndman Cemetery		23d. LOCATION (City or Town) Hyndman, Bedford Co., Pa.	
24. FUNERAL DIRECTOR Harvey H. Ziegler		ADDRESS Hyndman, Pa.		25a. REC'D BY REGISTRAR SEP 19 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12152

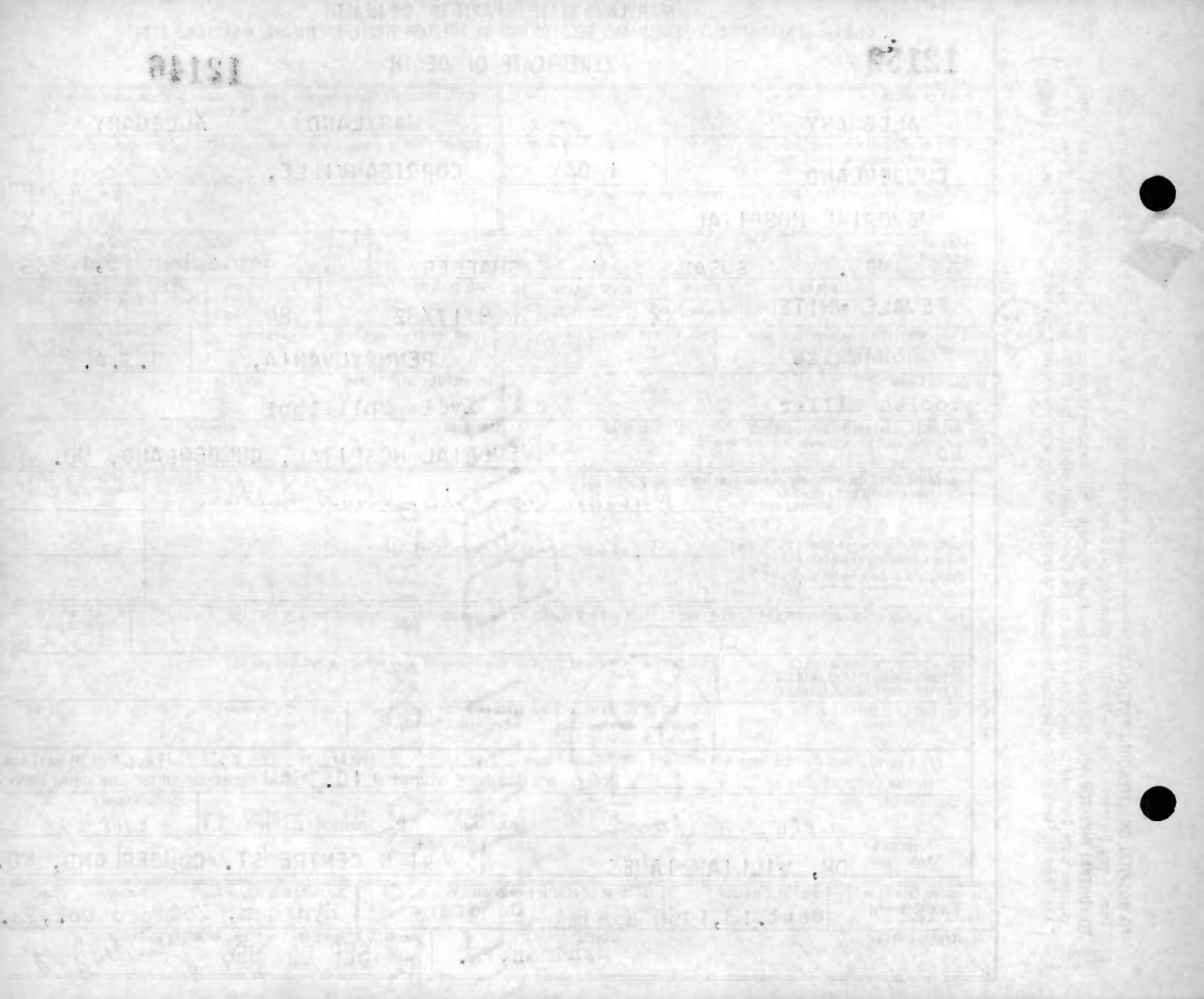
CERTIFICATE OF DEATH

12146

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

11. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 1 DAY		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CORRIGANVILLE,		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First MRS. SUSAN	Middle M	4. DATE OF DEATH Month September	Doy 15, 1966	Year
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 8/17/82	9. AGE (In years lost birthday) 84 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA,			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Tobias Miller			14. MOTHER'S MAIDEN NAME Lydia Phillippi		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			16. SOCIAL SECURITY NO.		
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Congestive Heart Failure DUE TO 4500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Genl arteriosclerosis DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Urinary					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) While		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Jan , 1966, to 9-15 , 1966, that (I) (we) last saw the deceased alive on 9-15 , 1966, and that death occurred at 10.30 AM causes and on the date stated above.					
22a. SIGNATURE W. James			22b. DATE SIGNED 9/1/66		
22c. PHYSICIAN'S NAME (Type) DR. WILLIAM JAMES			22d. ADDRESS 441 N CENTRE ST. CUMBERLAND, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 18, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Hyndman Cemetery	
24. FUNERAL DIRECTOR Harvey H. Feagler		ADDRESS Hyndman, Pa.		25a. REC'D BY REGISTRAR DATE SEP 19 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH
12158 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12147

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b 1 DAY		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> ND <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle HASKELL	Last SHIELDS	
4. DATE OF DEATH Month SEPTEMBER	Day 28	Year 1966	Year a. 5. SEX MALE b. CCLDR OR RACE WHITE c. 6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> d. 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> e. 8. DATE OF BIRTH MARCH 25, 1900 f. 9. AGE (In years last birthday) 66 yrs. g. 10. KIND OF BUSINESS OR INDUSTRY INDUSTRY h. 11. BIRTHPLACE (County & State, or foreign country) KENTUCKY i. 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JUNIOR EXECUTIVE	10b. KIND OF BUSINESS OR INDUSTRY JOHNS-MANVILLE	11. BIRTHPLACE (County & State, or foreign country) KENTUCKY	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MILTON SHIELDS	14. MOTHER'S MAIDEN NAME MARTHA MC KENNEY	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. 086-071-1189 17. INFORMANT DRIVE, BRADDOCK ESTATES, FROSTBURG	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PRIMARY HEPATOMA (LEFT)		INTERVAL BETWEEN ONSET AND DEATH 6 weeks		
1550 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		DUE TO DUE TO DUE TO		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) NONE				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 44A M	20f. (City or town) FROSTBURG (County) ALLEGANY (State) MD.
21. I certify that (I) (this hospital) attended the deceased from 9/28 1966, to 9/28 1966, that (I) (we) last saw the deceased alive on 9/28 1966, and that death occurred at 44A M , from the causes and on the date stated above.				21. I certify that (I) (this hospital) attended the deceased from 9/28 1966, to 9/28 1966, that (I) (we) last saw the deceased alive on 9/28 1966, and that death occurred at 44A M , from the causes and on the date stated above.
22a. SIGNATURE Martin M. Rothstein		22b. DATE SIGNED 9/29/66		
22c. PHYSICIAN'S NAME (Type) MARTIN M. ROTHSTEIN, M.D.		22d. ADDRESS 48 BROADWAY, FROSTBURG, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT 1, 1966	23c. NAME OF CEMETERY OR CREMATORIUM FROSTBURG MEM. PARK	23d. LOCATION (City, town or county) (State) FROSTBURG, MARYLAND
24. FUNERAL DIRECTOR MARTIN M. SOWERS		ADDRESS HAFFER FUNERAL HOME 60 W. MAIN ST., FROSTBURG	25a. REC'D BY REGISTRAR OCT 3 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

19151

19151



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12154

CERTIFICATE OF DEATH

12148

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10 HOSPITAL OR ATTENDING PHYSICIAN: Page 4 may be retained by the hospital or attending physician.				10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.			
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12155

CERTIFICATE OF DEATH

12149

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1 Day		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital						d. STREET ADDRESS Cresaptown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) George		First L.		Middle Snyder		Last Snyder		4. DATE OF DEATH 9	Month 21	Day 1966			
5. SEX M		6. COLOR OR RACE W		7. MARRIED WIDOWED <input checked="" type="checkbox"/>		NEVER MARRIED DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/29/96		9. AGE (In years last birthday) 70 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.		11. BIRTHPLACE (County & State, or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Samuel Snyder		14. MOTHER'S MAIDEN NAME Laura (Unknown)											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Miles Snyder		patient's chart		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5271 Acute Bronchitis DUE TO Pulmonary Emphysema and Cor Pulmonale.		INTERVAL BETWEEN ONSET AND DEATH 24 hours			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 20th, 1966 , to Sept 21st 1966 , that (I) (we) last saw the deceased alive on Sept. 21st 1966 , and that death occurred at 2:05 M, from causes and on the date stated above.		22a. SIGNATURE Wyand F. Doerner, Jr., M.D.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		p. MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Sept. 22, 1966			
22c. PHYSICIAN'S NAME (Type) Wyand F. Doerner, Jr., M.D.		22d. ADDRESS 111 N. Mechanic Street, Cumberland, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 24, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Levels Cemetery		23d. LOCATION (City or Town) (County) (State) Levels Hampshire W. Va.			
24. FUNERAL DIRECTOR John J. Hafer		ADDRESS 230 Balto Ave., Cumberland, Md.		25a. REC'D BY REGISTRAR SEP 26 1966		25b. REGISTRAR'S SIGNATURE Charles Judge							
VR A15 (4) 20 M 1/66													

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12156

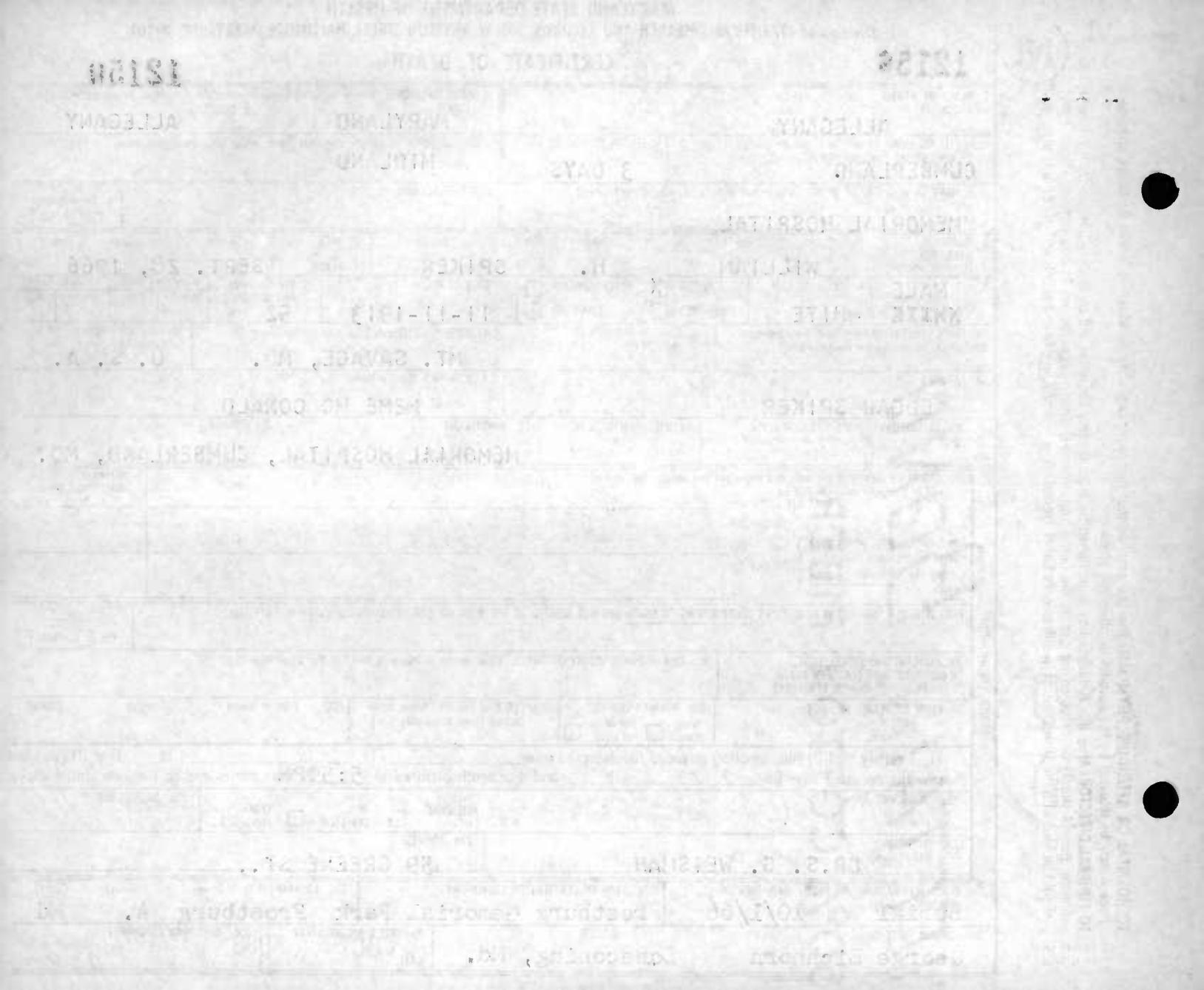
CERTIFICATE OF DEATH

12150

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician
director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2
should be filed with the State Dept. of Health prior to burial, cremation, or removal and any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 3 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDLAND		d. STREET ADDRESS 01-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM H. SPIKER		First	Middle
4. DATE OF DEATH SEPT. 28, 1966	Month	Doy	Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-11-1913
9. AGE (In years last birthday) 52 yrs.	10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) MT. SAVAGE, MD.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME EDGAR SPIKER		14. MOTHER'S MAIDEN NAME MEME MC DONALD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 332X		16. SOCIAL SECURITY NO.	17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral infarction		INTERVAL BETWEEN ONSET AND DEATH 30 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) 332X		DUE TO Hypertension	
stating the underlying cause (c) 332X		DUE TO Cerebral arterosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 9/25/66
20f. (City or town) 9/25/66		(County) 9/25/66	
(State) 9/25/66			
21. I certify that (I) (this hospital) attended the deceased from 9/27/66 to 9/28/66 , that (I) (we) lost saw the deceased alive on 9/27/66 , and that death occurred at 5:50 PM from causes and on the date stated above.			
22a. SIGNATURE DR. S. G. WEISMAN		22b. DATE SIGNED 9/28/66	
22c. PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN		22d. ADDRESS 59 GREENE ST.,	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/1/66	23c. NAME OF CEMETERY OR CREMATORIAL Frostburg Memorial Park
23d. LOCATION (City or Town) Frostburg		(County) A.	
(State) Md			
24. FUNERAL DIRECTOR George Eichhorn		ADDRESS Lonaconing, Md.	25a. REC'D BY REGISTRAR OCT 3 1966
			25b. REGISTRAR'S SIGNATURE James Judge



4
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

12157

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

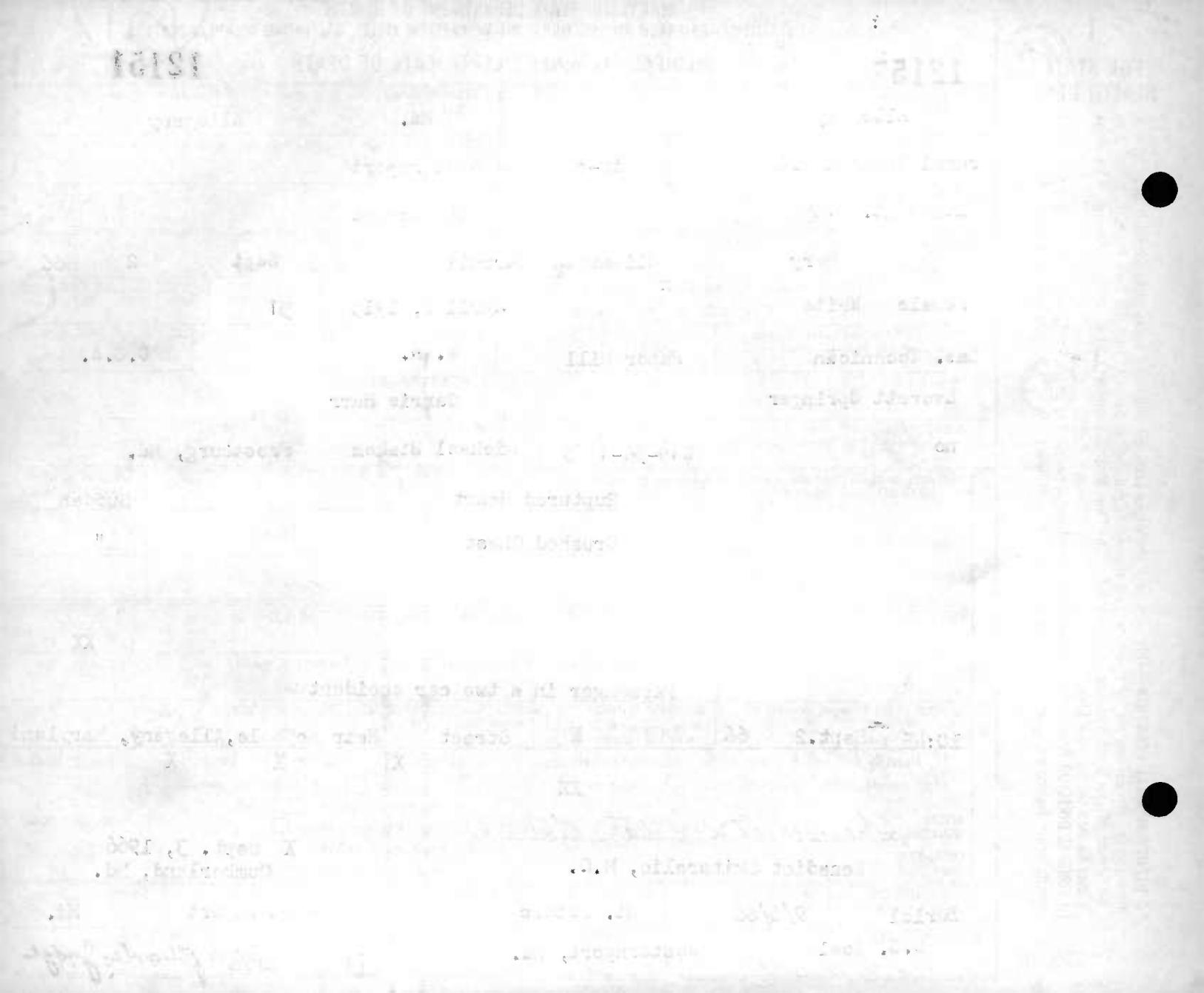
12151

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and file event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Westernport		c. LENGTH OF STAY IN 1b Min-s	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) State Rt. 135		e. STREET ADDRESS 235 Greene	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary Elizabeth Terrell		First Mary Middle Elizabeth Last Terrell	4. DATE OF DEATH Sept 2 1966
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 6, 1915
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lab. Technician		10b. KIND OF BUSINESS OR INDUSTRY Paper Mill	11. BIRTHPLACE (State or foreign country) W. Va.
13. FATHER'S NAME Everett Springer		14. MOTHER'S MAIDEN NAME Carrie Harr	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 214-34-1363	17. INFORMANT Michael Stakem Address Frostburg, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Heart DUE TO 8164 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Crushed Chest DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden " "	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in a two car accident	
20c. TIME OF INJURY Month, Day, Year Hour 10:15 p.m. Sept. 2 1966		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street 20f. (City or town) (County) (State) Near McCoole, Allegany, Maryland
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Sept. 3, 1966 Address (Street, city, town, or county) Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/6/66	23c. NAME OF CEMETERY OR CREMATORIAL St. Peters	23d. LOCATION (City or Town) (County) (State) Westernport Md.
24. FUNERAL DIRECTOR E.S. Boal	ADDRESS Westernport, Md.	25a. REC'D BY REGISTRAR DATE SEP 5 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

FIG.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12158

CERTIFICATE OF DEATH

12152

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the physician or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 2 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital - Frostburg, Md		e. STREET ADDRESS 247 Lower Consol Road	
3. NAME OF DECEASED (Type or print) Samuel Israel		4. DATE OF DEATH September 9 1966	
3. NAME OF DECEASED (Type or print) Samuel Israel	First Thomas	Middle S. Sr.	Last September 9 1966
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Sept 27, 1902
8. WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 63 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp	11. BIRTHPLACE (County & State, or foreign country) Allegany Co., Maryland
13. FATHER'S NAME John B. Thomas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service) Retired		16. SOCIAL SECURITY NO. 17. INFORMANT George A. Thomas, Route 2, Box 293, Frostburg	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Gastric Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 30 sec.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Possible Peptic Ulcer		? 1.	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) Hypertensive & Coronary Artery Heart Disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) X		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Artic insufficiency	
20c. TIME OF INJURY Hour a.m. X		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not at work <input type="checkbox"/> X	
p.m. 19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) X	
20f. (City or town) X		(County) X	
(State) X			
21. I certify that (I) (this hospital) attended the deceased from 9/1/66 to 9/9/66 , that (I) (we) last saw the deceased alive on 9/9/66 , and that death occurred at 9:15 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Martin M. Rothstein		M.D.	
22b. DATE SIGNED 8/10/66			
22c. PHYSICIAN'S NAME (Type) MARTIN M. ROTHSTEIN M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. ADDRESS 48 BROADWAY - FROSTBURG - MD 21572			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 12, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL Frostburg Memorial Park		23d. LOCATION (City, town or county) Frostburg, Maryland	
(State) MD			
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer		ADDRESS 230 Balto Ave. Cumberland, Md	
25a. REC'D. BY REGISTRAR SEP 14 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE SEP 14 1966			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #8 Film #G380 9/19/66 pg

CERTIFICATE OF DEATH

12153

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12159		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
a. COUNTY ALLEGANY		b. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 4 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BLOOMINGTON		d. STREET ADDRESS BOX 36	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LIDIA		First L	Middle TICHNELL
4. DATE OF DEATH SEPTEMBER 8 1966		Last 1893	Month 3-2-1883/
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 1893		9. AGE (In years last birthday) 73 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY BARNARD		14. MOTHER'S MAIDEN NAME RACHEL WARNICK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address MEMORIAL HOSPITAL, CUMBERLAND MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardiovas. dis.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>seen 12:30 AM</i>	
4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) <i>Generalized Arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>seen 12:30 AM</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (This hospital) attended the deceased from 12:30 , 19 66 to 9-8 , 19 66 , that (I) (we) last saw the deceased alive on 9-8-1966 and that death occurred at 12:50 PM from causes and on the date stated above.		22b. DATE SIGNED 9-9-66	
22a. SIGNATURE <i>W. F. Williams</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 122 S. CENTRE ST.
22c. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS		23d. LOCATION (City or Town) (County) (State) Westernport Ft Allegany Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/11/66	23c. NAME OF CEMETERY OR CREMATORIAL Philos Cemetery
24. FUNERAL DIRECTOR <i>E. S. Real</i>		ADDRESS Westernport Md.	25a. REC'D BY REGISTRAR SEP 14 1966
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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12160

CERTIFICATE OF DEATH

12155

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 27 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, 01-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			d. STREET ADDRESS 219 PACA ST.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First WILLIAM	Middle A. August	Last WEBER	4. DATE OF DEATH Month SEPT 26, 1966	Doy 19	Year 66
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED	NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2-21-1917	9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. DAYS Hours 0
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Heavy equip. opr.		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME GEORGE W. WEBER			14. MOTHER'S MAIDEN NAME EFFIE FROST			Address MEMORIAL *** HOSPITAL, CUMB. MD.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 214-07-0636		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF GALL BLADDER with</u> INTERVAL BETWEEN ONSET AND DEATH 1 year plus 1551 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>metastasis to the Liver</u> 1 year? (c) <u>TERMINAL CACHEXIA</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 27, 1966</u> to <u>Sep 26, 1966</u> that (I) (we) last saw the deceased alive on <u>Sep 26 1966</u> , and that death occurred at <u>3:35 PM</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Wylie M Faw Jr</u>				22b. DATE SIGNED <u>Sep 27, 1966</u>			
22c. PHYSICIAN'S NAME (Type) DR. WYLIE FAW		22d. ADDRESS 122 S. CENTRE ST.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/29/66		23c. NAME OF CEMETERY OR CREMATORIAL St. Luke's Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.	
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Md.				ADDRESS		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE Charles Judge
DATE OCT 3 1966							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

12161

CERTIFICATE OF DEATH

12156

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb LIFE				
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 308 ARCH STREET				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) ERNEST SYLVESTER WEISENMILLER		First ERNEST	Middle SYLVESTER WEISENMILLER			
4. DATE OF DEATH Month SEPTEMBER	Month 9	Doy 1966	Year			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 1-27-1896	9. AGE (In years lost birthday) 70 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. DAYS 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		11. BIRTHPLACE (County & State, or foreign country) MARYLAND				
13. FATHER'S NAME JACOB WEISENMILLER		14. MOTHER'S MAIDEN NAME ELEANOR (YUPA) WEISENMILLER				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO.				
17. INFORMANT PTS. CHART		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Neuritis		INTERVAL BETWEEN ONSET AND DEATH 1 day				
DUE TO (b) Myocarditis & Liver, infarction		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
DUE TO (c) Arteriosclerosis		5 days				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Jane	20f. (City or town) 1966	(County) to Sept 9, 1966	(State) 1966
21. I certify that (I) (this hospital) attended the deceased from June , 1966, to Sept 9, 1966 that (I) (we) last saw the deceased alive on Sept 9, 1966 and that death occurred at M , from causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
22a. SIGNATURE Clay E. Durrett		M.D. <input type="checkbox"/>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 9/11/66
22c. PHYSICIAN'S NAME (Type) CLAY E. DURRETT, M.D.		22d. ADDRESS 236 Virginia Ave. Cumberland, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 12, 1966	23c. NAME OF CEMETERY OR CREMATORIAL St. Mary's Cemetery	23d. LOCATION (City or Town) Cumberland, Md.		(County) Allegany
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR Charles J. Scarpelli	25b. REGISTRAR'S SIGNATURE Charles J. Scarpelli	
		DATE SEP 14 1966				

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12162

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12157

1. PLACE OF DEATH a. COUNTY ATLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb LIFE		b. COUNTY ALLEGANY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 524 CUMBERLAND STREET			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND 01-1		
3. NAME OF DECEASED (Type or print) SAMUEL G. WEISKETTEL			First	Middle	Last
4. DATE OF DEATH SEPT. 29 1966		Month	Day	Year	
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	8. DATE OF BIRTH JULY 13, 1891
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN			10b. KIND OF BUSINESS OR INDUSTRY FOOD		
11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME GEORGE W. WEISKETTEL			14. MOTHER'S MAIDEN NAME LUCY TRANARY		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 214 05 5811		17. INFORMANT MRS. FRANCES THOMAS	
Address CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION INTERVAL BETWEEN ONSET AND DEATH SUDDEN 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY SCLEROSIS DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> September 29, 1966 Address (Street, city, town, or county) CUMBERLAND, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT. 2, 1966		23c. NAME OF CEMETERY OR CREMATORIUM GREENMOUNT CEMETERY	
24. FUNERAL DIRECTOR BYRON KIGHT			23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD.		
ADDRESS CUMBERLAND, MD.			25a. REC'D BY REGISTRAR DATE OCT 3 1966		25b. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 20 DAYS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL						d. STREET ADDRESS RT 2 HAZEN RD. BOX 786					
						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First EMANUEL	Middle P	Lost WELSH	4. DATE OF DEATH	Month SEPT	Doy 20	Year 66			
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 9-20-1889	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/>	IF UNDER 24 HRS. Doy <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/>	Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carman Helper			10b. KIND OF BUSINESS OR INDUSTRY B&O RR Forge			11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOHN WELSH						14. MOTHER'S MAIDEN NAME ANNABELLE *WELSH (UNKNOWN)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 220-10-2501A			17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Terminal cardiac failure</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 week</i> 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Pneumonia, R. L. lobe, acute,</i> 3 week (c) <i>Hypertension & A.S. Coronary disease</i> 10 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>Gn. arteriosclerosis Diabetes mellitus</i>											
MEDICAL CERTIFICATION						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>								
20c. TIME OF INJURY Month, Doy, Year Hour o.m. 19 p.m.			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) 12:45 PM (County) 20 Sept. 1966 (State)					
21. I certify that (I) (this hospital) attended the deceased from 1 Sept. 1966 to 20 Sept. 1966 , that (I) (we) last saw the deceased alive on 20 Sept. 1966 , and that death occurred at 12:45 PM from causes and on the date stated above.											
22a. SIGNATURE <i>W. Alfred Van Ormer, MD</i>						22b. DATE SIGNED 20 Sept. 66					
22c. PHYSICIAN'S NAME (Type) DR. W A VAN ORMER						22d. ADDRESS 122 S CENTER ST. CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Sept. 23, 1966			23c. NAME OF CEMETERY OR CREMATORIAL Bald Hill Cemetery			23d. LOCATION (City or Town) (County) (State) Near Cumberland Allegany Md		
24. FUNERAL DIRECTOR ADDRESS John J. Hafer, 230 Balto Ave, Cumberland, Md						25a. REC'D BY REGISTRAR SEP 26 1966 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

10131

WELL TO STATION

2 MILE

1431

1000 FEET

1463.18

CHARTERED

1000 FEET

CHARTERED

060 X06 300 Y0500 S 15

1471.200 1471.200

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1000 FEET

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12164

CERTIFICATE OF DEATH

12159

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			b. COUNTY ALLEGANY		
c. LENGTH OF STAY IN b 20 DAYS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			d. STREET ADDRESS RT. 2, WILLIAMS RD.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First THOMAS	Middle B.	Lost WHETZEL	4. DATE OF DEATH SEPT. 21. 1966
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIOOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 2-17-1902	9. AGE (In years last birthday) 84 yrs.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Utility Man		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (County & State, or foreign country) MARYLAND	
13. FATHER'S NAME BEN WHETZEL		14. MOTHER'S MAIDEN NAME BARBARA PARKER		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>163X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		<i>Uraemia</i>		INTERVAL BETWEEN ONSET AND DEATH 10 days	
DUE TO (b) <i>Carcinoma left lung</i>				DUE TO 7mon	
DUE TO (c) <i></i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Sept. 10, 1966 to Sept. 21, 1966 that (I) (we) last saw the deceased alive on 19 , and that death occurred at 8:45 PM M, from causes and on the date stated above.					
22a. SIGNATURE <i>Clay F. Durrett</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) DR. CLAY DURRETT		22d. ADDRESS 236 VIRGINIA AVE.		22b. DATE SIGNED 7/22/66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 25, 1966		23c. NAME OF CEMETERY OR CREMATORY Zion Memorial Park	
23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany					
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE		DATE SEP 28 1966			

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12165

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12160

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Frederick Perrin		First Frederick	Middle Perrin
4. DATE OF DEATH September 18 1966	Month September	Day 18	Year 1966
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>
8. DATE OF BIRTH July 8, 1916	9. AGE (In years last birthday) 50	10. BIRTHPLACE (State or foreign country) Maryland	11. BIRTHPLACE (State or foreign country) Maryland
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman & Farmer	10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Norval Willison
14. MOTHER'S MAIDEN NAME Judy Perrin	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address Mrs. Paul Bucholtz, 221 Nat'l Hwy, La Vale, Md
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis, Right DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Coronary Sclerosis DUE TO (c) ----- INTERVAL BETWEEN ONSET AND DEATH Sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>	M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	22. DATE SIGNED September 18, 1966
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept 21, 1966	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS IOOF Cemetery	23d. LOCATION (City or Town) (County) (State) Flintstone Allegany Md
24. FUNERAL DIRECTOR <i>John J. Hafer</i>	ADDRESS John J. Hafer, 230 Balto Ave. Cumberland, Md	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE
DATE SEP 20 1966		DATE SEP 20 1966	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE M
HEALTH DEPT

12166

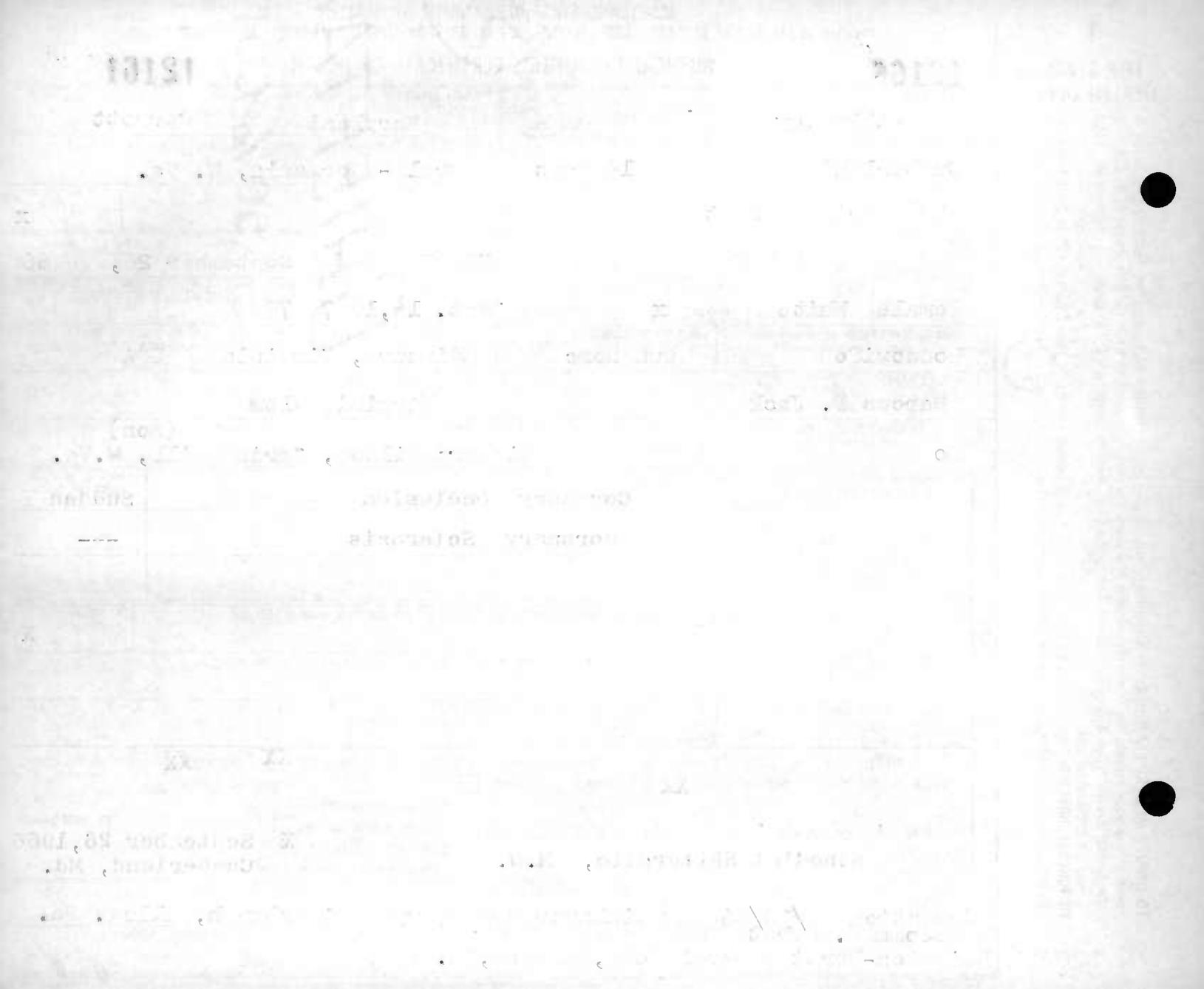
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12161

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 10 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 208 Spring Street		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NELLIE		4. DATE OF DEATH Month Day Year September 26, 1966	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED WIDOWED <input checked="" type="checkbox"/>		8. NEVER MARRIED DIVORCED <input type="checkbox"/>	
9. B. DATE OF BIRTH Sept. 16, 1887		10. AGE (In years last birthday) yrs. 79	
11a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY Own home	
11c. BIRTHPLACE (State or foreign country) Edinburg, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Marcus P. Jack		14. MOTHER'S MAIDEN NAME Virginia Clem	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address (Son) Richard Wilson, Spring Hill, W.Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH Sudden	
DUE TO (b) Coronary Sclerosis		---	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 9/30/66	
23c. NAME OF CEMETERY OR CREMATORIAL Beinhauer Crematory		23d. LOCATION (City or Town) (County) (State) Pittsburgh, Alleg. Pa.	
24. FUNERAL DIRECTOR O. Durst		25a. ADDRESS John O. Durst	
Leighton-Durst Funeral Home, Oakland, Md.		25b. REGISTRAR'S SIGNATURE DATE SEP 30 1966 <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12167

CERTIFICATE OF DEATH

12162

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 2 DAYS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS SWANTON		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		11-2		
3. NAME OF DECEASED (Type or print) PERRY		First WILLIAM	Middle WILT	4. DATE OF DEATH Month SEPT. Day 14 Year 1966
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 12-5-1893	9. AGE (In years last birthday) 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) SWANTON, MD.
13. FATHER'S NAME CEPHAS WILT		14. MOTHER'S MAIDEN NAME ELIZA V. DARR		12. CITIZEN OF WHAT COUNTRY? U. S. A.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 214-16-2257		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>loss of Hemorrhage</i> 5421 DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) <i>Perforated Marginal ulcer, Stomach</i> stating the underlying cause lost. (c)				INTERVAL BETWEEN ONSET AND DEATH 15 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Sore abdominal Ostie Anus, ASH</i>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-12 , 19 66 , to 9-14 , 19 66 , that (I) (we) last saw the deceased alive on 9-14 19 66 , and that death occurred at 12:15 PM from causes and on the date stated above.				
22a. SIGNATURE <i>W. P. James</i>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 9/14/66	
22c. PHYSICIAN'S NAME (Type) DR. W. P. JAMES		22d. ADDRESS 441 N. CENTRE ST.		
23a. BURIAL, CREMATION, BURIAL (Specify)		23b. DATE THEREOF 9/17/66	23c. NAME OF CEMETERY OR CREMATORIAL Gaster	
23d. LOCATION (City or Town) (County) (State) Garrett County Md.		25a. REC'D BY REGISTRAR DATE SEP 26 1966		
24. FUNERAL DIRECTOR <i>E. P. Boral</i>		ADDRESS Westernport, Md.	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12163

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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12163

1. PLACE OF DEATH a. COUNTY Allegany		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 3 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		d. STREET ADDRESS 360 Frederick Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Joseph, Edward		First	Middle	Last	4. DATE OF DEATH Month Sept.	Year 3	Doy 1966		
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 12/1/05	9. AGE (In years last birthday) 60	IF UNDER 1 YEAR Months 9	IF UNDER 24 HRS. DAYS Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Technician		10b. KIND OF BUSINESS OR INDUSTRY Amusement Co.		11. BIRTHPLACE (County & State, or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S. A.			
13. FATHER'S NAME Edward Wolford		14. MOTHER'S MAIDEN NAME Mary (of Wolford) Wolford		15. INFORMANT Mrs. Irene O. Wolford		Address 360 Frederick St.			
16. SOCIAL SECURITY NO. 214-05-6227		17. Patient's chart		Cumb. Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion with shock		DUE TO 4201		INTERVAL BETWEEN ONSET AND DEATH 1/2 days					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Pulmonary Emphysema; arthritis		(b) Coronary arteriosclerosis		years (?)					
DUE TO 4201		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary Emphysema; arthritis		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from August 31 , 1966, to Sept. 3 , 1966, that (I) (we) last saw the deceased alive on Sept. 3rd , 1966, and that death occurred at 10:50A , from causes and on the date stated above.		22a. SIGNATURE Wyand F. Doerner, Jr., M.D.		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> a.m. <input type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED Sept. 5, 1966				
22c. PHYSICIAN'S NAME (Type) Wyand F. Doerner, Jr., M.D.		22d. ADDRESS 826 Mechanic Street 414 N. Mechanic St.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/6/66		23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.			
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Maryland		ADDRESS		25a. REC'D BY REGISTRAR DATE SEP 8 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

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YOUNG, ROBERT

1007 FOREST RD

WILMINGTON, DE 19803

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